Philip Kurtz
Video Transcript

Intro by Marsha Hystead:
Well, I do have the distinct honor of introducing Philip Kurtz.

Philip actually was the first person I thought of when we were talking about speakers. To have him come and share the vision of his company and actually Philip's vision for how to get better health care in America.

And so I invite you to come up, Philip, and tell us more about your vision.

Philip Kurtz:
Thank you, Marsha.

I want to thank Marsha and Hailey Sault for inviting me to speak today.
I think it's a real honor to get an opportunity to be in front of you all.

You heard a little bit about me, but if you don't mind, I'm going to ask you all a few questions so I know who my audience is here.

Can you all raise your hand if you're involved with health care in any way right now? OK, that's pretty much everybody in here. If you're part of a health care delivery system can you raise your hand? Great. If you're involved with employee benefits in any way, raise your hand. Okay, one. Alright. If you're involved on the insurance side of the delivery system, if you'd raise your hand. Okay. And if you all have employees that you either—in your organizations that are let's say—if you have a hundred or more employees, if you could raise your hand, in your organizations. Okay, about a third of the audience. Thank you.

So to give you a little bit more background of myself. I'm a CPA by early training. So what am I doing in health care? But actually, in the mid-80s I kind of really focused on writing software for hospitals. You heard Marsha talk about building a clearinghouse. I

had 2,000 hospitals on that platform, so I learned a lot, began to develop a lot of analytics for health care, and actually building revenue cycle management.

Since that period of time, I've really been very heavily involved in actually looking at patterns and trends. And over time I've discovered a lot of things that we're doing that are having unintended consequences. And so I think those are really important.

The last five years I've been the CEO of a population health management company. And I believe, very strongly, and my organization believes, and part of the reason why I'm here, is I believe that we can reduce health care costs by 50%. I'm going to give you why I believe that and what I believe the steps are necessary to make that happen. And, at the same time, I believe that we've got a real opportunity. You know, when you look at the United States and our health care system and you compare ourselves to other major industrialized nations, we're number one in health care cost and we're number 36 in life expectancy.

You know we always talk a lot about—we have a shortage of doctors—we don't really have a shortage of doctors, we really have an abundance of disease. And I'm going to show you some of that today. And maybe hopefully, I can part with you all today, where you learn something that'll maybe make you think about—sort of the paradigms you're trapped in—and what the opportunities are. And I think if I share that with you our health care system is a little backwards to some of the other industrialized nations out there. So we're going to point out that—just to kind of make it give you a perspective right now—the United States spends almost twice as much per capita on health care as the next largest nation, and that's Japan. Japan's life expectancy is 86. Our life expectancy actually went down this last year, it's the first time in about 60 years that our life expectancy actually went down. And yet, we're spending twice as much.

So when you look at the trends, they're unsustainable. And I'm going to show you this in a second, but the patterns are obviously growing and our health care is growing. So when you look at what's happened in the last 20 years, our employees are paying 259% more for their health care cost and employers are paying 239% for those employees' health care costs. They're shifting a little more of the burden, obviously, to employees while at the same time our overall inflation rate in the last 20 years has been 51% up and our worker's earnings are up 68%. The problem is the workers aren't really taking home more take-home pay because they're spending more of their monthly budget on

health care than they were a long time ago. They're spending about 25% of their monthly take-home pay on health care. And 20 years ago it was around 18% or 19% so you can see that the burden is getting much greater for them.

So, when you really look at our health care, I'm going to talk more specifically about the opportunities for larger employers, but don't misunderstand that the opportunity doesn't exist for smaller employers and for other people in the health care system. Because I believe that you can network these folks together and really provide population health management—and I'll talk more about that.

We are very much a data driven organization. We know that health care is running about two and a half times the rate of inflation, we have data that basically shows this. We get data from all over the place—and I'll talk a little more specifically about it in a few minutes. But anyway, basically about 10% to 15% of your population is going to drive 80% of your cost. So this formula is really simple. In order to basically reduce that cost, you find those people before they become that 10% statistic. And that's where we really fail the health care system.

We're under a health care system that's fee-for-service. So the best way to improve your fee-for-service is to basically wait until the patient is a trainwreck to start addressing their needs. That's why even today we have filled emergency rooms, urgent cares, because these people have waited until the condition has gotten so bad to go into it. Why? One of the reasons why is the average patient right now who goes to a cardiologist is going to be out $750 to $1,200 out of pocket. So did they want to go to the cardiologist when the primary care physician says you need to go to a cardiologist?

So guess what? They wait until an ambulance brings them into the cardiac care unit, into a hospital, where it gets very, very expensive. So if we can find those people, we can find those 10%, then we can actually start reducing those costs by helping them get better later on. So what do we have to do? We have to reduce those costs because they become barriers in health care.

The CDC, the Centers for Disease Control, maintains that 86% of our health care costs are attributable to preventable treatable chronic disease. These primary diseases that run most of our costs—particularly for employers—cardiovascular, diabetes illnesses, related illnesses, muscular skeletal, cancers, pulmonary, arthritis and behavioral health.

Those are driving our health care costs. Those are usually the top 5, 6, 7 that you see inside an employer's data.

We get their data, we get as much data as we can—two or three years' worth—and we go through and we look at what's happening and what the trend lines are in those.

So if you look, there is a pandemic going on inside this country. And it's certainly our lifestyles. Our lifestyles have changed a lot. We've gotten much bigger. And the obesity rate that we have in the United States is driving a lot of these other diseases.

And so you can see, without me going through them, but you can see a lot of the diseases that are a result of that. If you look at the high-dollar claims, seventy-five to 80% of the people that come in and drive those claims are obese. So, it doesn't mean that you necessarily won't get cancer because you're thin, you can. You can have heart disease when you're thin. But basically a lot of the drivers that are going on right now in our health care system is obesity.

When you look at obesity, you actually want to go back into the 1980s. You would see that the obesity rate in the United States was around seven or eight percent. The states started reporting this in 1990. And so you can look at this and you can see, if we go up to Minnesota here, you can see that basically in 1990 the obesity rate was below 15%. You can see places like Colorado was in the 10% range. So when you look at 2000, you can see Colorado still remains in a pretty low rate. But you can look at basically, the whole nation here, is beginning to grow and obesity rate in 2000 and then again in 2010. You can see now our obesity rate and all the south is around 30 to 34%. Most every place else except for Colorado, Colorado is still down there in that 10 to 14%, considered to be the the healthiest state out there. But everybody else is growing now over 25%. So now we'll take it to 2015, just five years later, and you can see that there are three states down there, four states, West Virginia, Louisiana, Mississippi and Alabama. But basically, those are now at an obesity rate of over 35%.

So in just a quick 30 years we've taken our obesity rate 300%. And most places, if obesity was considered to be a disease, that would be considered pandemic. But what's the first major outcome of obesity is type 2 diabetes. Also, diabetes now is the number one reason why people miss work. Lost productivity in 2007 was estimated to be 56 billion in a day or in 2016, 117 billion. That's lost productivity as a result of type 2 diabetes. A diabetic will spend two and a half times more money on their health care

than the normal patient that's a non-diabetic will. Now that doesn't mean that a non-diabetic doesn't have problems, but basically a diabetic will spend considerably more.

So when you look at the diabetes rate in this country back in 1980 <1990>, type 2 diabetes was less than 2%. And basically, there were a few states that weren't reporting at that particular time in 1990. But you can see overall, basically the population around the United States, you can see the western states, Colorado, Utah, Arizona, those basically were in the less-than-3% in 1990. The rest of the country was in the 4 to 7%. And again, as you look at this, in 2000, you can see the whole country was now up in that 4% to 7%. Mississippi and Alabama were in that 8 to 11%. And you can see now most of the south, all the way across the country is pretty much in that 8 to 11%. We have a few states, again West Virginia and Alabama that are in that 12 to 15%. And then, you look at where we are in 2015 and now we've got about six or seven states that are now in that 12 to 15%. So nationally, we're ranked about 12%. It's still growing. It has not stopped growing. So as a result, you can see that this would be considered a pandemic. But for some reason, we sort of ignore it.

When we go in, we have a lot of municipalities, when we take municipalities and we do a risk assessment, we find anywhere from 30 to 45% of the population who are pre-diabetics, 90% of that population's not aware that they're pre-diabetic.

So there are three steps that we look at to reduce health care costs. The first, and the most important by far, is prevent disease.

If you go and every year you get a normal checkup and you get a health risk assessment and everything is okay, and you're great, and you go out and you continue to eat healthy, be active, physically active, the American Heart Association says you need a minimum of 150 minutes a week to maintain your health in moderate exercise. And moderate exercise really means that you really need to get your heart rate up there at 80 to 90% of your aerobic rate. So that's moderate exercise.

But even walking helps considerably. People who walk on average 15 to 20 miles a week are much healthier than people that are sedentary. Unfortunately, we're one of the most sedentary countries in the world.

So when you look at preventing diseases, you know what are the steps that are really necessary to prevent diseases?

You begin by collecting data and risk assessing the population. If you go in, and you know it’s so amazing what we find, so many people that go out and they take their population, they might buy. We provide on-site clinics but we don't do fee-for-service. Fee-for-service is a barrier into health care. And I'll talk a little bit more about that.

The fee for service where a patient goes in and has to spend money on their health care is more likely spend money on their pets than they are on themselves. They take better care of their pets than they do themselves. They take better care of their cars than they do themselves. You know, you get the car, you buy a car and every 10,000 miles you’re supposed to change oil. They got a notice in the mail and they go out and they take the car, they take better care of their car than they do themselves.

So part of this is getting into the habit of wellness and taking care of yourself. Part of this is to basically get historical claim data, get all the medical records you can. I don’t mean just for the patients themselves or for the population, but also, medical records. We use medical records that come from literally hundreds of hospitals and other databases to actually compare our population to. So as a result, we have much, much better information to know what's effective and what's not effective. Then we do a personal health assessment. There are a lot of people that don’t use the health care system.

We had a patient, not that long ago, who hadn't been to the health care system for 7 years. And, we did a personal health assessment on that patient, found some risk factors in there, called him up, asked him to come into the clinic. He came into the clinic, that night, he had a stent put in. And the surgeon told him that this probably saved his life because his widowmaker was 98% blocked. And he was not aware of it; he knew he was feeling not as well as he used to. He knew he’d put on about an extra 45 pounds from where he was. He was only 47 years of age. He still had young children at home. Kids involved in sports and everything else. And you know, the doctor said if you hadn’t died from a heart attack, you would have lived with maybe a 25 to 50% reduction in your heart muscle. So you would have been incapacitated the rest of your life.

This person was a high-caliber engineer in a company and made a lot of money and he was a very valuable asset to that company as well. So not only did we get a nice letter

from the patient, we got a nice letter from the company. And they felt like this was one of the greatest benefits that they supplied to their employees.

We take all of this data and we actually risk assess the population. We know from their socio-economic information that we can compare to others—who's likely to be at risk, who's likely to go into the hospital, what are the reasons that they're likely to go into the hospital—we can make those predictions.

Along with the personal health assessment providing all that information in there, and being able to—and this is typical—this is actually a real population of 3,679 members in a plan. And so the way they came out was that there were about 8% in the high risk and 50-some percent in the moderate risk. And those are people that we really want to address out there because some of those moderates are going to become high risk.

And then the low risk, those are people we want to pat on the back and say keep doing what you're doing. Just do—more of. You know, more activity and more healthy eating.

So basically, in our analytics—and this is very important—our first cut, which is really what we call descriptive analytics, that's going to provide how many people are pre-diabetics. How many diabetics are there? How many diabetics that are in compliance with their medications? We can look at and find that people haven't taken or gone in to fill their prescriptions, aren't taking their insulin because they haven't filled a prescription for over a month after they've supposedly run out of insulin. We can look and see the people that have actually been diagnosed but never even picked up a prescription and should be under medication, but are not. These are people that end up in the hospital in the emergency room.

We can take those and summarize all those and report back to an employer. And then we can strategize on how to improve upon that. We can actually take that data and predict what's going to happen over the next year without intervention.

And basically, right now in the main-street health care, they really are very much focused on providing care only when the care is seeked by the patient.

We have to get in front of that. We have to tell the patient that they have risk factors that they need to have addressed. Because they may not be feeling it or may not be aware of it. So it's very important that we engage those people early on.

Finally, the prescriptive is to develop the strategies. Maybe we have to offer incentives. Maybe we have to provide education. We do quite a bit of diabetes education.

So we go in and talk to the employees about diabetes and what it means and what the outcomes could be. And, as I mentioned before, it's not unusual for us to find a third of the population that is pre-diabetic—and 90% of those people are not aware of it.

But you know what? It’s a major impact. When we go and run intervention and do diabetes education to that working group, we sometimes see 80 to 90% effective rates where these people have taken their pre-diabetics and moved them back, often to a normal range.

So once they become conscious of it, educated, educated to what they can do, you basically have saved maybe a whole generation of diabetes. It’s a major impact that you can have.

So the major benefits of doing the data analytics and the risk assessment, is being able to actually start addressing that risk. And so you identify patients on a trajectory to become high risk. You turn missing inconsistent data into meaningful information that drives clinical action.

We are actually using artificial intelligence to basically get to a point where we can make even more precise predictions. So as we regurgitate this information over and over again, it gets better and better at its predictions.

And, we reach out to those high-risk patients, educate them, get the patient themselves to commit to their treatment protocol. We have them sign off on what they're going to be doing. Once they have that, they have that commitment level. Rather than just telling them what to do, we explain things to them. We give them some options that will have the highest impact on lowering their health care costs.

You look at the pre-diabetics,the diabetics, diabetics that are under medication, diabetics who have gaps in care, so I’m just kind of using that as an example. I could use hypertension, I could use muscular skeletal problems, anyway, all of those things are things that we go through on each disease state.

And we also take those informations—so you might find a patient that's got six or seven comorbidities versus a patient that's got one—they take a different kind of treatment protocol and a different kind of education.

So then, you've got to really improve the engagement cycle.

On main-street health today, many people will go into and wait in a waiting room, only to be sent then to a lab, only to be sent then to an imaging x-ray or CAT scan or MRI. Then they have to go and wait also, in line, to get a drug at Walgreens or CVS. That's a half a day event.

You know, most school systems, if a teacher's gone a half a day, they have to bring in a substitute. If they're gone an hour, they can get back to work and it doesn't cost the school system anything for them to be out. So there's great pressure for teachers not to leave the workplace to go to the doctor. Well, that's not going to be healthy and the school system is going to pay a lot bigger premium on the cost by forcing that teacher to stay at work.

So part of this is, you have to improve the customer service.

I've always felt like, if we had a lot of choices, the health care system wouldn't be the place that we would go. It would be like a restaurant that service is really poor, they keep you out in the waiting room even though maybe things are you know—I always tell doctors sometimes that your customer service is really bad. I don't understand how I hold you in higher esteem than I do a maître d' at a restaurant but they do much better on their customer service than you do. And they're surprised.

You know, I had to go to a urologist not too long ago. I called, I was 8 minutes waiting on the phone before they answered the phone. When they finally answered the phone it was 11 minutes before they got somebody who could look up and see my lab value that they told me to call back that afternoon to get. Then, when I called, they didn't have it yet. After now 19 minutes on the phone all together. And then the next day when I called it took another 11 minutes before they answered the phone. By the way, when I went took the lab I said I wanted to be at 8 o'clock because I got a lot of work going on I need to get right back to work. It was 8:35 before they saw me. I was the first patient at their lab. I could hear them in the back room talking about what they watched the night before on TV.

You've got to improve that experience. You've got to be responsive on the phone. You've got to be responsive when they get to the clinic. You've got to see them within 10 minutes of arrival. This all works. You just need the data to drive that. You'd be surprised.

When the flu came out, we put extra people on the phone. We asked our doctors to work overtime last January and February—and they did. And we were still able to see 90% of our patients within 10 minutes of arrival. That doesn't mean parked in an exam room, that means hands-on by the doctor.

Second thing is lower cost per unit.

There's a lot of expenses that we spend in the health care system. Number one: there is a real opportunity to build your own networks.

Right now we all belong to major networks like United or Cigna has a network or Aetna, or Blue Cross Blue Shield. Those networks have a wide diversity of providers in them. Almost every provider belongs to all of those networks.

And so basically, the disparity of costs between those networks are very, very high. You can negotiate your own narrow networks or you can be a part of a group that negotiates your own narrow networks and you can funnel and really educate those employees and provide incentives for those employees to go to narrow networks. And you can cut those costs substantially. I mean very substantially.

If you make it more simplistic by taking away the patient copay, the costs that are associated with that patient copay, they'll reduce that for you. They don't like chasing patient copay. The cost to chase patient co-pay is substantial and they'll give you that discount.

We've been able to negotiate below ACO—Accountable Care Organization—fees based upon that ability. Or go in and do a capitated rate with a hospital system by taking a whole population to them and then you can build some guide rails on that and reduce those costs.

There's a lot of people who have surgery that are perhaps obese, have back problems, hip problems, knee problems. And what do they do? They go in and have surgery on

those areas. About seventy-five, 80%—even by the orthopedic surgeons—will tell you those are unnecessary and only last about a year. So unless you kind of address the fundamental problem of losing weight—you'd be surprised once you lose weight and teach people how to exercise through physical therapy, you avoid the surgery altogether. That's still a lot cheaper.

You know, gastric bypass surgery or gastric sleeve surgery is very, very popular. But one of the things that most surgeons require the patient to do is lose 35 to 40 to 50 lbs before they even have the surgery. Well, they're on a great process to lose that weight. Why don't they just continue that? And when we've taken patients that have done that, we've avoided the surgery altogether. So there's a real opportunity to save cost in that area.

Our providers spend almost 30 minutes on average with a patient. In main street it's about 10 minutes. So in that time, we do a lot of procedures. For example, I had a suspicious-looking mole. My doctor removed the mole, sent it to a pathologist to look at it. Now on main street they would have sent me to a specialist. But in this situation they were able to do that and accomplish that. And since it wasn't a fee for service—it's a fixed fee—you know, there's basically no added cost for me having that procedure.

We also use in our organization, econsult. This allows our doctors to actually communicate with the specialist. So before sending them to a cardiologist, he can communicate with a cardiologist any place in the United States who's on this prescription. You can provide, let's say, a calcium scan. Or you can provide an EKG. You can provide all this information before the cardiologist says yeah, that patient really needs to go see a cardiologist or no that patient really doesn't. I put this person on statins.

And so, we were able to avoid close to 50% of referrals. When you send somebody to referral, they're going to spend 1,200, $1,500 right off the bat. And that's something the patient doesn't want to do because they don't necessarily have the money for it. So you can reduce cost again, those unit costs, by reducing the amount of specialty conferences you have to do.

Coaching versus surgery? Again, lifestyle management. Sometimes it takes a coach—an outside person—to help hold you accountable and teach you the right kinds

of foods to eat, teach you the right kind of activity given your lifestyle—where you live—and basically help you accomplish your goals.

Right now, if you go to a Medicare facility, Medicare basically sometimes is a loser in the health systems or Medicaid, if they have a high population. But that means you, as an individual, might have to pay more for surgery because they're going after self pays and insurance and charging higher fees for those.

There's a lot of surgery centers, for better or for worse, don't necessarily take Medicare or Medicaid and are giving much more competitive rates to commercially covered folks. And some of those provide and pay for even the travel to get there. So that's a consideration. And they have much higher outcomes because they're not acute care centers or disease centers where there's maybe staph infections and so forth that are involved.

I already mentioned narrow networks. I'm not going to go through a lot of detail on pharmacy. We actually dispense pharmacy out of our clinics. We pay about 60% of what retail is. There's a lot of people in the middle of all of those, pbms, rebates that are going back and forth. We try and clean up all that, make it simple and very transparent. And also too, we generally—in the retail business—and most state laws require that you can only provide a 30-day prescription, so they have to keep coming out. I'll use omeprazole as an example. You provide a 90-day prescription it's about $0.17 a pill through our dispensing. If you get a 30-day prescription through the retail, it's about $0.45 per pill. So you can see the cost reduction.

Same thing with my little procedure that I had at the urologist. They charged me $148 for. That same procedure, not procedure but lab test, that same lab test, I would have paid $5 for. So what we do, is we pass all those lab tests, at our cost. We know what that cost is. On main street, that's one of the areas where they make up some of their losses. Because they generally charge 150%, 200% of Medicare on those. So you're getting charged about usually two to three times as much as what the true cost of that lab is.

The third piece is to reduce your administrative cost.

Believe it or not, the actual true administrative cost in health care is 25 to 30%. And when you look at all these administrative fees that you have, you have disease management, case management, collection fees, contingency fees, consulting fees, wellness programs. Believe it or not, if your company is self-insured, they're probably paying a lot of these fees and they come through their third party administrator or their administrative service organization. Sometimes it's bundle prices, but they have all these fees built in—network fees, claim payment fees.

So we have we have a large employer as ours, they operate in 11 states, and basically their health care cost—they were spending fifteen million dollars a year just on their network fees. They've eliminated those 15 million dollars a year and that's almost totally paid for the clinics that they now operate in all these states. So just network fees alone, almost paid for the clinics.

One of the things that they do, by the way, is they bypass all the insurance companies. There is no Cigna, there is no United Healthcare, there is no Blue Cross organization. They pay their own claims. For us, we do their case management, disease management. They have their own narrow network. And so, all of that basically has reduced their administrative cost. They've got basically three people in their organization that pay claims for 22,000 people.

Now you know, if they were to go and have Cigna or somebody else pay those claims for them, they would have paid almost ten times the amount that they're paying themselves, to pay those claims. So you can see, in their situation, they literally have reduced their cost to less than half the national average.

So when you follow these three steps, you can have a significant impact. And so basically, if we go back to that very first slide, you can see that, in this situation, this is the intervention time. Their company's health care costs are going up just along with inflation. And basically, when they run intervention and they start pushing these three steps in, they can basically have a major impact to where they're running about half of that inflationary rate.

We had a manufacturing facility up in Grand Rapids, Michigan whose first year they saw a reduction of 11% in their health care cost. And, the industry in Grand Rapids went up 6%. So they went down 11% but the industry was 6%.

So you can see, they're on that trend line. And they've continued to use these processes to reduce their cost and that was in their first year and they're now in their third year. So they've continued to see their costs decline against the national trend line.

So we of course, with the help of Hailey Sault, we've tagged this, you know, our "Care at the Center." That's what the CareATC stands for. And we all believe very much that we all have it within ourselves—the power to be well.

So with that, thank you.