HealthJoy - Co-Founder and Chief Operating Officer at Endear Health

Interview conducted on January 30, 2023

Topics

Medicare Advantage, Member Engagement, Health Plan Industry, Sales Strategy, Data Integration, Market Competition

Summary

The Tegus Client is interested in understanding the member engagement world from an employer market standpoint as well as the health plan space. The Co-Founder and Chief Operating Officer at Endear Health explains that the member engagement world looks different for small and large health plans, with larger health plans determined to own almost all parts of member experience in-house. The Co-Founder also discusses the challenges of building member experience platforms and the different approaches taken by various companies. The Tegus Client expresses concern about the difficulty of differentiating in the market, as many companies offer similar solutions. The Co-Founder and Chief Operating Officer at Endear Health explains that most commercial solutions have already picked a tool and are using it to varying degrees of success. The Co-Founder also discusses the sales process, the difference between the MA market and the Medicaid market, and the need for gathering data from the senior population to inform stars, which can impact a plan's long-term success. The expert predicts that within the next 12 to 24 months, there will be more competition, but the market is big enough to support multiple players.

Expert Details

Co-Founder and Chief Operating Officer at Endear Health.

Co-Founder and Chief Operating Officer at Endear Health. The expert's goal is to simplify the healthcare experience for Medicare members. They are well-versed in value-based care, telehealth services, member engagement, and supplemental benefits to payors.

Prior to Endear Health, the expert was the Former Emerging Business Group at Anthem, leaving in 2021. They managed the early-stage investments specifically focusing on healthcare and medicare advantage investments.

The expert was also the Former Senior Strategy Analyst, Corporate Development at Castlight Health, leaving in May 2020. The Expert was hired at Castlight Health in Aug 2017 as a Senior Financial Analyst, Strategic Finance to help buildout Castlight Health's operating model. The Expert was responsible for controlling all of the input to all of Castlight's finance reports and plans for the future which had a close view of how the company ran and understanding the top line. The Expert also helped with wall street earnings calls, getting their forecast out, and everything relating to strategic finance including potential acquisitions. After two years in that role, the Expert moved into the Senior Strategy Analyst, Corporate Development role where he helped to spin up a new health plan product that Castlight was actually going to be selling to health plans instead of employers. The Expert reported to the Head of Strategic Finance as well as the Head of Strategy.

Tegus Client

Hey, really appreciate your time being here today. I’ve been just intrigued in general about the member engagement sort of like cost savings world. I want to understand it from an employer market standpoint. But I am also are aware that there are options for the health plan space as well. So maybe if just talk about a bit of background, kind of like, in general, maybe in your own words and then share a little bit about what inspired the creation of Endear Health and the willingness to step into this market.

Co-Founder and Chief Operating Officer at Endear Health
Yes, of course. I eventually came to California to work at a company called Castlight Health about six years ago. After that, moved over to Anthem. And to wrap it up here, essentially when I was at Anthem, I saw a similar trend occurring that Castlight had been founded upon, which was this flood of point solutions entering a market, an audience that had no idea how to access them, how to use them and you know what, someone who was paying for it all and spending a lot of money to set these programs up and seeing extremely low engagement.

So in Medicare Advantage, specifically, we're looking for seniors in value-based care to do a ton of things that should keep them healthier and happier. So that could be getting their second opinion. That could be using telehealth services. That could be getting free rides to and from a doctor. You name it, plan to try and get members to do it. But asking a 75-year-old with multiple chronic conditions to manage four or five different tech log-ins was simply not a successful way to approach it.

So kind of started Endear on the backbone of someone needs to pull this world of supplemental benefits together. Someone needs to wrap it in a lens that really makes sense to this population. And someone needs to make it sellable into payers, who are the ones giving most of these things out. So I'll pause for a second there. That's the short of where we came from.

Tegus Client
No, that's extremely helpful, awesome background. So just stepping to the engagement world for health plans, so I guess, that's what the market looked like. So I have pretty good understanding of the employer market and agree with your assessment of the challenge that you described.

What does the member engagement kind of world look like on the health plan side? I know there are companies out there, like League or like Wellframe, like Zelis, some member portals they have. So how are they doing? Is there an opportunity for multiple players? Is your product differentiated? How does that world work?

Co-Founder and Chief Operating Officer at Endear Health
So I would say that the short of it is there's a variety of ways to answer that question. In general, the member engagement world looks a lot different for a sub-30,000 or a sub-50,000-member health plan than it does for someone who has one or two million members or even more. Anthem has 40 million members. So the first thing that's kind of worth noting is that the big versus small is certainly a big thing in the health plan world.

Where if you're a large health plan, you are extremely determined to own almost all parts of member experience in-house. So the Aetnas, the Anthems, the Humanas, they continue to try and build solutions that will really solve for this. Most of these solutions are aimed at their commercial market. It's where the vast majority of members are. It's where they believe the most tech-literate members are, which is mostly true.

And to this date, we've really only ever seen anyone take the approach that, "Hey, if I build something that is truly simple and accessible for anyone, I can give it to all my populations, and it will be successful." So you haven't really seen a ton of separation in terms of how people approach building these platforms. When we were at Anthem, Anthem had a deep relationship with Castlight. It was kind of using Castlight as their in-house solution while it built its own.

The one that it built was called Sydney. Sydney spent more money than you'd ever expect to be spent on Sydney. And I was put into that platform. It's not terrible. They rolled it out to most of their commercial members. If you've ever been on Anthem insurance, you can download the app. It does okay for someone who's 35 and knows how to use technology. The issues are that they don't have the engineers that could build good integrations with point solutions.

So it doesn't solve all the challenges of actually bringing everything into one place. And again, it's not really built for multiple different populations. So Anthem originally had tried rolling Sydney out to their Medicare Advantage book. And it just flopped. Members had unique needs. They had unique challenges. And they had to pull that tool back. My guess is they've spent enough money on Sydney. They will try and adapt it and roll

it out again.

But when that happened, our team was responsible for looking externally and digging out what solutions were on the market that could help us solve this challenge of, one, doing it better in commercial because Sydney wasn't working very well; and two, trying to find a tool that would work better for value-based care and Medicare Advantage. So when we did this, we did an RFI. We looked at Wellframe specifically.

We looked at League Health specifically. We looked at Sharecare. We looked at Zipari. We looked at Rally. We kind of looked at all the solutions. Certainly, at least from Anthem's perspective, they had a very low appetite to work with any member experience platform that was owned by a different payer. Naturally, they don't want to pay United. So that ruled out the Rallys of the world, don't want this immediately.

When we looked at the Sharecare and there are other really huge players, they could really come in and they could check off every single box on an RFI. They kind of have done it all. The issue is they're carrying in years of tech debt and very low historic engagement. They've really never done their job well. So it was really challenging for us to get momentum internally to work with someone who's been in the market for five, 10 years and really hadn't figured it out.

Because at the end of the day, if I walk into a room and I sit down and say, "Hey, what I have in front of you is the newest-age front door," you pretty much get half the people to fall sleep immediately. It's been used too much. It's just too kind of commoditized at this point. There's nothing unique about it. League was making a little bit of traction internally with Anthem, just because it seemed it had really strong connections. It seemed it had an aggressive team of salesmen.

But I never got the sense in their product they were doing almost anything different. And Wellframe was the same boat. They've worked with a few Blues. So Anthem was considering them because the Blues are just looking out for each other shoulders. Then Wellframe got caught up in that HealthEdge acquisition from the Blackstone roll-up as that kind of paused pretty well. The other one that we were looking at was Rightway, which I was kind of a little bit more distant from.

But actually people thought that their ability to direct members to specific providers is much stronger in that setting. Again, it wasn't enough that we kind of had pushed things forward rapidly. And the final company that I'll really call out in this space is a company called HealthJoy. It is certainly one that I probably respect the most of any company in the space that's not Endear. We called up HealthJoy at Anthem because they have phenomenal NPS.

They have customers that love them. And we said, "Hey, would you work with us?" And they just said no. And that's one of the things that when I worked at Anthem, if I called somebody up and said, "Hey, we're thinking about putting our 40 million members on your platform," I got calls to the CEOs immediately because everybody wants that revenue opportunity. HealthJoy was the only customer I talked to when I was at Anthem that said no to us.

Because they simply said, "Hey, we're focused on building out our book of business here with the smaller people. We don't want to have our roadmap to get destroyed and our customers love us." And since then, they've raised a $60 million Series B or something. They're really doing just fine. So the team over at the HealthJoy seems like they've really got it figured out. But again, the biggest difference between member experience products is really just the continuum of how high touch they want to be.

At the end of the day, without really changing much of the peer tech side of things, given that they all look and feel the same, the only difference really is, "Hey, do we want to act as just a log-in with nobody behind it?" Or do we want to give a little bit of help behind it? So maybe we have a chatbot or some kind of a directing tool that helps member find services. Or do we want to go all the way to being a concierge service and say, "Hey, pick up the phone, we're always here to talk to you, we'll solve that problem"?

And pretty much all of the companies will fall somewhere on that naturally to the full high touch and the author of Humana's full high touch. And then you really have some of the shared carriers that are about as low touch as possible, really just more about checking off boxes but not really moving the needle. But that was a long monologue. Did I answer what you were looking for?

Tegus Client
It sounds to me from what you're saying that it's really hard to be differentiated, right?

It's like they all sound the same. They all pitch, a, “we have a member engagement layer. We have some sort of steerage. We can like steer to other point solutions. We can help people find doctors.” How do you get out of that narrative, right? It feels like everyone falls into it and there seems to be no escape, right?

Co-Founder and Chief Operating Officer at Endear Health
Yes. So it's a good question. So for one, the vast majority of commercial solutions have some product out there. They picked one of these tools. They're using it to some varying degree of success. So when you are coming in, you are competing with something. The vast majority of Medicare Advantage offers close to nothing for their members.

So if you're not Anthem, if you're not United, if you're not Humana, when that 65-year-old goes to find that information about their deductible or wants to know what's covered, most of their plans have pretty much no log-in and they're just going to offer a phone number that you have to call it. So for one, we can make more traction quicker.

Because simply put, there's really nobody else selling into Medicare Advantage yet that at least that offers a tool that says, "Hey, I just spent five minutes at it. It's very clearly built for your population here." It makes more sense, Sharecare with 1,000 notifications and flashing lights, et cetera. Naturally, the big thing for us is trying to say, "Great, we're a front door for now that helps us get in there."

If front door does not where Endear wants to be long term, Endear wants to be a data play that really helps honestly these health plans to figure out what benefits they want to use, figure out which are the best to use, figure out the most applicable way to use them and improve their star ratings as kind of a wraparound service. The issue is just to be that fulcrum of where all these plans, their point solutions come together.

So you can really start saying, "Hey, this is the right one you should be using. This is how you should use it. You have to get members to access things through one place." Because that's not happening at all right now. The necessary step was to create the front door. So I think for us, it really is just a point-in-time thing. You've got to prove you can do it. After people are there, we can move on to the more interesting value props.

But the final thing I'll call out is differentiated is that we are willing to be as high touch as necessary to achieve a level of engagement the plan is okay with. And what that means is for a 65-plus population, for a senior population, they're still going to show up at community centers. When they have questions about plan things, they will literally show up at the local Anthem office and knock on the door. So there's a lot of just room for improvement here.

And what you can't do, you can't just text members a link and expect that, that's going to drive them all to a behavioral change. So right now, they're pretty much only getting brochures in the mail once a year. Maybe you text them or e-mail them about a specific thing. But for a lot of companies trying to penetrate Medicare Advantage, you're bringing in a product that doesn't fit this population perfectly. And you're not bringing in any specific learnings on how to engage this population.

How do I actually get an older adult to work with me on a regular basis? And the answer is you're going to have to show up. You're going to have to be where they are at the provider systems in-person in their geographies at the brokers. And that's something that eats at your margins really quickly if you're a large company like Sharecare and you're trying to continue to grow.

So it's just not very appetizing. So for us, we are going to approach plans, we could say, "Hey, the product fits your population better, which makes sense, you're listening. And on top of that, we'll spend the money initially to figure out of all the different ways your seniors might want to work with us, what are the ones that actually work."

And we've kind of done a lot of research on that front. So we're pretty confident there. But I would say style of engagement, the UX of the product and eventually the integrations that we have involved in our

ecosystem will probably be our biggest differentiating things. But I'm very excited to not call myself a front door as soon as possible.

Tegus Client
How big is the MA market if you're removing all the big guys, right? Because it sounds you say, okay, if you take out the UHC, the Anthems, the Blues, right, Cigna plays in MA. But whomever, right, like the big MA guys, how many plans are there for you to go to sell into, right? And is that a big enough market in general?

Co-Founder and Chief Operating Officer at Endear Health
Yes. No, it's a fair question. So I would say from a pure lives basis, the Big four have around 50% of the lives. Naturally, this market is growing extremely fast. It finally just overtook Medicare as the largest form of insurance for seniors. So from a lives perspective, about 50% are associated with the Big 4. From a number of plans perspective, that still leaves us 300, 400 plans to go out and sell into.

Naturally, every single day, it seems like another plan is getting started, often very culturally competent or like population. And we think that, that's a great trend. Because you could actually build benefit packages that fit people and not just like, "Hey, let's give everyone in California the same United plan."

But I would say our plan, at least in what I can share here, is that really to try and work with a lot of these smaller payers that have no IT teams, that have no website, that are looking at all the baby boomers, 10,000 of them that are aging in every single day and saying, "I need to give them something. I have no chance of building it. What are the cheap solutions out in the market that fit this population?"

And then eventually moving upstream into the Anthems, the Humanas of the world after we've really shown how to do it effectively. We have conversations going with some of them already. And it's a scary thought to get 500,000 or one million members in your platform before you've really been able to demonstrate you know how to make them do things. Because naturally, you're going to have to spend a lot of money to achieve your goals or this whole thing is going to stop pretty quickly.

Tegus Client
And yes, as you said, I mean, it's a growing pie, right?

Co-Founder and Chief Operating Officer at Endear Health
Rapidly growing pie. And I would say that even most of the regional Blues. So that the individual states, whether you have like Louisiana, who just got acquired, or California or Arizona, almost all of those are also looking for a similar solution. They're big enough to have a great revenue opportunity. But they don't have any homegrowns either.

Tegus Client
Yes, so you mentioned before when you were talking about Endear also and you were talking about some of the competitors, the integration space. What are some of the things that you or any of these other players are expected to integrate with when you sell to these plans? Is it existing tooling, existing data, existing clinical teams? Where do you expect to play ball with both from a tech and a services standpoint?

Co-Founder and Chief Operating Officer at Endear Health
Yes, another very fair question. So I would say that the short of it is that if you are coming in with the expectation of owning the member experience, so actually being the first place a member will go to when they have a question, so that token phrase, front door, if you're agreeing to do all the things that are associated with that with the health plan, then essentially, you have to integrate with everything.

And I'll explain what everything means. But to the short of it is that anything someone would ever want to know about a plan, they can't go to a different place to find it. So that means that if they need to have a question about their claims, you need to integrate with their claims fee so that, that's in one place. If they need to do and find a provider, that can't be a different link out. That's going to be pulled all into one place.

Like you said, the nurse lines, the support teams, that all needs to be integrated into one system. So when you're thinking about what these integrations look like, when you're working with someone who is owning it all, it's a lot more tricky than if someone says, "Hey, I want to be the front door. Can you just kind of power some of the integration layer behind things?" At which point, you can be a lot more choosy.

But for us to work with a health plan, right now, do everything for them, put ourselves in the shoes of someone that has no IT team, first thing that we're going to have to integrate with are any benefits they're currently working with. So if you're already working with a transportation vendor, if you're already working with a grocery delivery vendor, we need to get in contact with that team.

We need to have a conversation about what their protocols look like, what APIs do they have available for us to connect into, what type of data can we get to start flowing. The issue is in Medicare Advantage, a lot of the resources that people are giving members are very hyper-local. So it might be a van company that just exists in one county in Minnesota and nowhere else. So the ability to build a pure tech integration and track rides and things like Uber might not be available.

So then it comes down to what level of integration can we build, how can we still make the experience better. When we're working with someone that has an Uber or Lyft already there, it's a very easy integration for us to pull that in, allow the rider to track everything in-house and actually call the ride. So the next things we're going to have to integrate with are some form of their internal data lake.

So this is candidly where the market gets the most tricky to play in. But that's such a huge variety of how internal health plans will store their internal data. Will they normalize it upfront? Will they do a small batch normalizing later? Are they kind of creating protocols? Or are they just holding storage elsewhere?

So for us to come in there and figure out how to get all of the member information, all of the doctor information. How to match it appropriately really becomes an exercise in working with that specific health plan, which is candidly why when we talk to investors, what they should ask and what they do typically ask, it's just that concept of how custom dev shop do you need to be to pull this off.

How much can you actually roll out a repeatable chassis that does the same integrations with the same health plan? Or is every single one a bit of a unique beast? The issue is it's more unique than I want to admit. If you have the right team together, you can still make some things in a way that really speeds up the process.

So I would say that when we think about going to small customers first, my biggest fear is that it will require too much engineering work to justify the number of lives that we're going to be having on this platform. I think we have the team to be able to pull it off. But certainly, that's where a lot of other customers have chosen not to get into this world, to only sell to the large players. Because it's just so much engineering work to pull it off effectively.

But essentially, the short of it is any time a member has access, wants to know anything about their plan, all of the integrations to all of those services need to be built to link it into the front door. So I can kind of say yes or no to things if you have questions on what would need to be built. But it's a list of 50 or 75 things.

Even something as simple as authenticating a member, like how is that internal health plan verify that member is legit? Some have very great systems in place, some have stuff. The good news is that world will stay complicated because each health plan will kind of continue to build their own software. Like we won't have a winner in that space anytime soon.

But the benefits that are entering the space, the good news about them is they're at least coming in all more tech-literate and they're so many of them. So certainly, the number of integrations we expect to build there should peter off as you kind of have built the ecosystem to everything. The issue is linking it to the underlying health plan base will always be a bit more manual.

Tegus Client

How do you think about the member-facing versus the staff-facing tech? So you think about like at HealthJoy, for example, they sell it to an employer PPM, right, and then their employees and their independents have

access to the HealthJoy member app. They chat in. They have questions about the benefits, yada, yada, yada.

So it's only a member-facing option. Then on the other side, you think of Wellframe, right, which sells the staff-facing tech and they have a member-facing tech, too. How do you see that play out in the MA space? Do you feel like you need to have both sides? Or are you guys providing both the member-facing app, which I know that kind of says yes?

Co-Founder and Chief Operating Officer at Endear Health

No, it's a good question. So at least at our company, we're not going to provide any additional bodies. We're not going to be the ones that pick up the phone calls. We are going to build tools that are not just member-facing, but they are internal plan or provider-facing as well. The most important thing for us is being able to inform what we call the member 360, plans that have different forms of it.

But essentially, that one view that a call center rep or an internal health plan person can pull up that says, "For member so and so in Idaho, this was the last time she saw a doctor. These are the benefits that she has available to her. These are the ones that she's used recently." This is the HRA that we had to fill out at the start of the year that says, "Hey, she just had a family member died. She doesn't have a car, et cetera, et cetera."

That allows you to actually form the full picture. Right now, health plans are operating, at least in MA, with close to no data on the member in terms of what they want, how they use those things. And the issue is naturally with star ratings indexing so heavily on member experience, specifically rating of a plan, there's a huge amount of revenue that is essentially up in the air every year. And a plan won't really know if it's done well enough until those ratings come out in the fall.

And I don't know if you saw how last year went. But plans just got pummeled because they removed the COVID guard rails and it was just a bloodbath. So in general, we're prioritizing building a member-facing piece initially just because when a member screamed no or yes, it goes a lot louder than what the internal teams say. But our plan is naturally to layer in the internal side as well, mostly focused on call center and being able to serve the people that are going to call in and talk to the members.

But eventually going further into plan design or before these programs are actually put into place, you'll be able to see a larger picture of all the usage of the programs. So you can really say, "Hey, let's go with vendor A versus vendor B versus vendor C," which was a huge problem when I was at Anthem just because you get naturally 15 pitches for very similar services for you to take the time to contract with a specific program or benefit.

It takes, I don't know, six months, if you're working really, really fast, typically closer to a year. Then at Anthem, I would need to find the right population to give this program to, to kind of test it all out, get it in their hands, launch it, send e-mail and text message after text message after text message, so eventually a few people clicked in on it.

And then about 12 months from there, we can look back and say, "Hey, let's scan through some spreadsheets, figure out if we have any trends that are worth noting." And that whole process is going to take you about three years, which means that if you've made the wrong decision on which vendor program X, Y, Z to give your members, you don't know for years, which means that if other stuff have come to market, you're now behind. So the goal is to be able to enable plans to make those decisions much faster.

Tegus Client

Have you had any of your clients ask you for the staff also? Or do you think that they're pretty comparable with their own staff in terms of, "Hey, can you be the tech only? Or hey, can you also be the tech and the staff?"

Co-Founder and Chief Operating Officer at Endear Health

Yes, it's another fair question. I would say that they don't have the right answer. They don't know what they want yet. So I think if we came in and said, "Hey, the right answer is we're going to bring 50 of our staff.

We're going to sit them down. We're going to teach you. We're going to use them in place for a year or two and then transition them off," I think they would say, "All right, let's think about it."

And if we said, "Hey, we do no staff, we just train your staff. You guys know the right pick, et cetera, et cetera," they say, "Okay, let's think about it." Like I said, there's just simply no one that's done what we're kind of describing in Medicare Advantage before. So there's no use cases to really rely on.

We naturally, as a primarily tech company, don't want to have this type of margins that a company bringing all those people with us everywhere we go. We're also aware that if we start having struggles internally with the plan and it feels like, "Hey, we need to help them out in this regard. This is a pain point for them," we'll scale to kind of deal with that at that time. And Castlight had built a whole separate arm of its business to do just that. It took one and a half years to stand up and it wasn't super successful, at least initially.

Tegus Client

How does the sales process work? How engaged are these plans? How long does it take to close a sale? I know for selling into bigger plans, usually there is like a pilot period. Is it the same for the smaller ones? It might be a tough question to generalize. You guys are pretty green still. But just high level, how does a sale mostly work with this product and this market?

Co-Founder and Chief Operating Officer at Endear Health

Yes. So in general, the sales process in this market is not pretty. It's probably one of the more challenging things that we've had to deal with and any company coming in will have to deal with. And it's actually a moat in itself. Because once you cross it, it's so hard for the people to come after you. But in general, you kind of have to approach it, this is going to sound a cop-out answer, but with all of the classic sales strategies.

So for one, you need to have a demand generation team that's out there scanning the market for RFIs, for RFPs that are making cold calls to members of all the health plans, digital teams, to their marketing teams, to their government businesses, thinking about us being Medicare Advantage. They have a value-based team trying to find a way in there, getting them on the phone, giving them just enough to be interested and trying to pass kind of up the chain.

We forecast, at least at Castlight, I can speak to that pretty concretely, we typically forecasted 36 months start to finish on a bottoms-up sale to a health plan. That's pretty similar to what I've heard around the market. I have heard of some people that are come in that's closer to 24 to 30. But at the end of the day, it's a two year-plus cycle.

Naturally, the other way you can approach it is to go top-down within a health plan, try and find the highest-up executive that has any sort of power and go down into their teams from there. Issues with that being that everybody has 30,000 priorities in their health plan. Even if you find the exact right stakeholder and they pass you along to their exact right team, unless you have done it at the exact right time of the year, well, then their budgets are already set.

So immediately, their first thing they're trying to figure out is, "Hey, how do I pull this off without hiring new people, without spending dollars I don't have?" Because pretty much everyone will go in to a health plan and offer free. Everybody knows that the long-term value of having a health plan customer vastly exceeds any cost you'll spend in that initial one to two year trial period.

So it just behooves you to say, "No matter what it takes, let's get in there." Once the health plan has decided to work with you, they'll let their engineering teams actually start going back and forth, and you can become that sticky solution that kind of glues a bunch of things together and becomes very unappealing to rip out. But the issue is everybody knows that everybody is offering free. And again, even when I was at Anthem and someone would offer me free, it doesn't mean free for me.

Because I still know that I'm going to have to come in to engineering teams and stop what they're working on to do other things, which is just a huge cost. And again, if you're not hitting them typically in the exact sweet spot of somewhere between September and November, where they're still figuring out budgets and they can carve out things that are necessary, it's really challenging. Fun part about going to health plans include between Thanksgiving and New Year's, pretty much no one works.

Executives all have their PTO kind of expire at the end of the year. So you pretty much have people take a month off. That's really challenging when the year starts. And then all of a sudden, for the first two months of the year, all that matters is kind of making sure the members that have signed up for executing appropriately, so not a lot of new projects get done there. So you really have to try and engage them at the right time of year to work your way through it.

For us, what we've seen being successful is kind of being able to get honestly lucky enough. I mean, working to put ourselves in the right situations, where you find a project that involves your need. So they've already set aside cash or some kind of team to work on it. And you're able to find the right stakeholders to go top-down at the same time to help you shortcut some of the process and quickly win an RFI or an RFP. At the end of the day, there really is no just perfect, seamless way to do this effectively.

I would say that the only shortcuts I've seen are people that can sell effectively across a lot of the regional Blues. So because so many of the Blues are small plans, they kind of have pooled a lot of their resources to do investing, to do vendor procurement, to do a lot of different things. So if you're able to kind of break into that network and demonstrate that you're able to do what you say you're going to do effectively for one of the states.

Maybe do it for South Carolina so you could probably get Rhode Island. You could probably get Minnesota, you could probably get Michigan and a bunch of other states to really give you the chance to prove it. Whether or not they'll buy in, that's not always a guarantee. I see people go from one Blue to 10 or 15 Blue a lot quicker than it often is to go from one random health plan to 10 other random health plans.

Tegus Client

Is that kind of a hope per se for you guys in terms of like going to the Blues? Or do you put the Blues in the market that you showed before around they try to build around and it's not easy to sell to them?

Co-Founder and Chief Operating Officer at Endear Health

Our plan is to serve Blues. A lot of the things about the Blues that are appealing, like I said, the quicker sales cycles, the fact that they are always looking over their shoulder to see what another Blue is doing. But even more importantly, that extends all the way to the types of programs they give and the benefits they work with. So because they're all looking at each other, they end up instead of, let's just, for example, say, it's 40 different benefits.

Maybe there are 10 different benefits and the same kind of vendors that all the Blues are going to use. So our ability to build a repeatable solution for the Blue network is much stronger than it is to pick up a regional health plan after provider-led plan, after X, Y and Z. But for us, we're convinced that it will be both a commercial and a margin success if we can kind of pull that off, to be determined.

Tegus Client

Are these solutions internal? I know on the employer market how things are priced. It's very PPM-heavy, right? But how does it work in this space? Is it also PMPM or some sort of flat fee for the whole book of business? Are there pricing based on performance in any way or form?

Co-Founder and Chief Operating Officer at Endear Health

Yes, it's another good question. I would say that the pricing gets a lot of the ones you just called out. So the most mindless and just kind of straightforward way is to just approach it with a PMPM. You can go with a PEMPM, so like a per engaged member per month. So it really involves that you've actually gotten them to do what you want them to do. We typically don't want to push with that initially.

Because again, we don't even have a perfect sense internally of what the percentage of members that health plans even want to use these services. So tying ourselves just for that is not too ideal. I would say that the other models that come about are just one flat fee, so especially for pilots, whatever, per $50,000, per $200,000, per $1 million just doing it a one-time fee that expires at some point.

What excites a lot of plans is certainly the ability for a service like ours to take on risk to really say, "Hey, we'll put 100%, 80% of our fees at risk if we don't drive to a specific engagement level, if we don't get people to engage in the right type of programs or you don't see the cost savings you're looking for." The issue is for us because we don't have internal services built, we don't have an internal diabetes program, right?

So we can't necessarily guarantee that if you put your diabetes members in our platform, we'll improve their cost of care. But what we can guarantee is that if you, the health plan have selected the right Livongo, the right Omada, the right diabetes program and you've done your job appropriately, we'll get more people to use that.

However, the actual difference that long term has to cost of care is too ambiguous right now for us to state or ask more revenue on. So we've stayed away from it. I think long term, our goal is to be someone that is able to assume risk. Because you're able to shortcut contracting a lot easier to health plan if you're able to do so effectively. At this stage, it's just not practical.

Tegus Client
Is there a huge difference between the MA market and the Medicaid market? It seems like you are building a lot of tooling and know-how for the senior people. Does any of this translate into that market, both, I guess, from a product and service standpoint but also from a sales motion? Or is it like a completely different planet?

Co-Founder and Chief Operating Officer at Endear Health
I would say it's not a complete different planet. It might be kind of a few hundred thousand miles away. But it's not a completely different planet. I would say that a lot of what we're trying to build from a simplicity of solution, accessibility-focused tool that is extremely lightweight and cost-effective for a plan, that should be able to persist across different markets.

We have had a lot of plans that say, "All right, we do this with MA. Can we put commercial on you? Can we put Medicaid on you? Can we put our duals members on your platform?" For us, it's something that we'll consider because again it's a revenue opportunity. But it's not something that we're laser-focused on solving for initially.

I think the biggest things that make Medicaid and the duals market appealing are that they're able to really finally start taking risk. So, so many of these plans have started offering risk-based services for Medicaid. And anytime someone is taking on risk of a member, we feel very, very strongly that you'll be incentivized to spend additional capital upfront to keep that member healthy and therefore capture the difference on the long-term health of the member.

Naturally, most of those things we're going to look to provide, a lot of them are digital tools, a lot of them are digital programs, all things that require typically some consolidator to come in there and make it easy to digest for a member. I think when you think about it, it's probably not my best brands I'll use today. But I think that Medicaid members typically, there can be a lower tech literacy rate than even in Medicare Advantage than Medicare.

That is rapidly changing, especially because a lot of these plans are even offering their members free tools. They might even offer them a cheap phone, so they can connect to a lot of the programs they're looking for them to connect to. So that gap is present. But it's not enormous or insurmountable.

So I think that there will be a solution that ends up being able to play effectively in Medicaid duals and Medicare. I don't believe there will be a solution that can do all of those and commercial in a way that wins the whole market for quite some time, just because I think that each population really still has its unique need. And unfortunately, we have not been able to build technology that really does work for everybody quite yet.

Tegus Client
One thing that remains from something that you said before was the outbound engagement side of it, right?

So when you talked about your experience at Anthem and when you're looking at a solution for them, you mentioned one of the reasons why you were attracted to the existing players was because they show that engagement is low. A lot of what navigation players do, right, they have sort of like a marketing activation kind of function, right?

So they send e-mails out to the employees, "Hey, this is HealthJoy, this is Rightway, please have this whole shebang of outbound stuff." Do you expect the plan to handle? Or is that something that comes with the fee, right? So like you say, "Okay, we charge PMPM for Endear." And that includes our marketing sort of strategy to get members into the Endear app on service.

Co-Founder and Chief Operating Officer at Endear Health

Yes. That's a good question. I would say there's a little bit of variety across the market. There are certainly solutions that we talked to that we're not interested in doing a ton of that. That we're willing to really trust that the plan will message their own members effectively about the tools that are available. And whether or not they believe the plan would do it right or whether or not they just decided it wasn't worth the fight to try and get direct access to members.

That does not always clear. But I would say that in general, plans are extremely hesitant to allow solutions that come in there and be able to talk to their members directly without having 15 signatures go on each message that gets sent out. Naturally, it makes sense because you don't want the Endear coming in there and saying something stupid and ruining 100 million members and screwed you over.

But it also means that for us to be able to say, "Hey, let's get very specific targeted messages out to this group for this reason right now," can really be challenging. So for us, how we approach it is to say, "Listen, you're seeing engagement rates at X, Y and Z. You believe internally those rates should be A, B and C. We're willing to help you get to A, B and C or kind of just below it."

"However, if you don't follow our engagement fundamentals, our tool list and our toolkit of how we have to actually talk to these members, then we're not going to be held to the engagement you see," which pretty much starts the conversation by saying like, "If we're not going to be able to use all of your marketing channels, if we're not going to be able to get language that we write in your brochures, then it's pretty much not worth our time or we'll do it with no expectation of success."

And some plans are still interested in doing it their way and saying, "That's fine. We just want something to try. That's not appealing to us." We've kind of turned down people to work with us that way. That was always a big problem with Castlight was trying to sell to health plans and having them not want us to message.

We have found partners already that are willing to let us kind of own all of those marketing channels. And I would say that eventually, we can probably sell that more as some of the side services business. For us right now, it's really just a means to an end for us to be engaged there appropriately. And we don't trust the plan to do it well, so we might as well.

Tegus Client

So you do kind of prefer an offer A, when you buy them, they'd like to ideally own all the communication out through your channels.

Co-Founder and Chief Operating Officer at Endear Health

Yes. We make that extremely, extremely known early in the conversation. Because if that's going to be a big fight, it's probably not worth us really talking for too long.

Tegus Client

Have you explored how companies like Sapphire and even in ones like Gartner, I think on the employee side, they have these things like incentives and other practice to get engagement right from membership? Is that applicable to your population? Or is that a bit too tech-heavy, right?

Co-Founder and Chief Operating Officer at Endear Health

I would say that, yes, incentives are relevant to this population. Previously, the rules were a lot stricter around what you could give to members and how you could give it to them specifically in a value-based setting, when you were just kind of paying people to sign up almost at one point back in the day.

Certainly, it's a big thing in the commercial world. The $15 gift cards available in your account once you've signed up and filled out who your provider is and sign for one survey, that's very much there. In Medicare Advantage, I would say it is for the vast majority not around yet. But that's changing pretty rapidly. Are you aware of over-the-counter cards and the digital wallets that are entering Medicare Advantage?

Tegus Client
No.

Co-Founder and Chief Operating Officer at Endear Health
So I would say one thing that's kind of worth noting is one of these newer-age benefits that members are receiving are essentially little spending cards from their plan. They're called like over-the-counter cards. Typically, they were literally taken to your in-person pharmacy, where you could buy reading glasses, you could buy TYLENOL, you could buy a very specific list of health-related things.

And they would pretty much give the member just carte blanche to go out there and say, "What makes the most sense for you? This is a benefit that will keep you healthier, you decide." Naturally, as the world has become more tech-heavy, that is a challenging thing to do. And a lot of people want to buy things online and just have them ship to us.

So there's kind of been this whole world of companies that have entered, offering plans the ability to give their members a digital backbone and really a digital wallet. So a number of these companies would be like Lynx, financial health care. NationsBenefits is doing a little bit of it. Pen Bay Health Options is doing a little bit of it.

But for us, if we were to partner hypothetically with one of those solutions, we can go to a plan and really say, "Hey, we can offer your members an incentive program. They will have a digital wallet that when they log-in to, there is $15 to $20 preloaded on it for them filling out the surveys." On top of that, it's integrated with a variety of marketplace things. So that a member can track all their dollars in real time.

And two, click order something that's sent to their house and really complete the entire process of sign-up, reward delivery, reward purchase, all in a very short time frame. This world, I would say, is coming around quickly. It wasn't here previously. Plans love these over-the-counter cards and the wallet simply because it kind of allows them to stop taking the stance.

Why do we think we know what's best for a member? We know how much we're going to spend anyway, let's just give it to the member. And it's getting closer and closer towards almost paying them to stay with the plan. So I'm curious how long CMS will let it kind of run wild. But for right now, you're seeing Anthem. You're seeing some of the biggest plans in the world really start turning to these benefits as a way to entice and attract Medicare Advantage members.

So naturally, those things go hand-in-hand with incentives, which for us, we would love to be able to do. We're just not going to own an incentives program all in-house initially. So we can't walk to a plan that doesn't have one and offer it. If they want to offer one or they're already thinking about it, we can facilitate it.

Tegus Client
Any thoughts coming from the Castlight world, you've seen a lot of price transparency plays out there, right? You have from the Healthcare Bluebook that show the red or green or HealthSparq that have kind of like, "We'll pay for your co-pay if you go to these doctors." You have your Turquoise that raise money on some like pure data play, given regulations, some expectations on No Surprise Bill Act, like in the future, would expect providers to kind of provide an estimate of what things will cost. Like more broadly speaking, how do you see that world? Is there something interesting there for you guys in terms of just price transparency and steerage?

Co-Founder and Chief Operating Officer at Endear Health

I mean, we'll have to deal with that world. It's too part of what everyone expects to receive to not have any way of presenting some of that information. I can totally speak to my time at Castlight and my time at Anthem to say that some of the newest legislation has made me 1% hopeful about our ability to do this better in the future in terms of really trying to require people to offer this information up.

Naturally, everybody is behind dumping. And they still make it really hard for someone to discern what things are going to cost. I'm fighting with two competing factors, which is that, one, there's no world where U.S. consumers should not know how much something is going to cost before they get it done. That is just the fact, like they will always push for that. So this will always be a conversation.

And the competing force against that is that it is near impossible to ever get that information right as things are currently set up. So I would say right now, when you think about the Castlight world of trying to both offer information on just how much things are going to cost, so really pulling that member's information card, trying to assume what services are going to get taken care of at the provider and then matching up the bills for those services with previous claims.

And then two, actually trying to say, "Well, then who the hell do I want these people to go to?" So what is quality? Am I going to look at 30 years of clinical data to try and say, "I think this doctor did it right"? Am I just going to push everyone to the Harvard medical doctors? Am I just going to push everyone to Cedars-Sinai? So that concept of where you actually want to push people, I don't think anyone has done it perfectly right now.

I think that someone like that, what Endear has to do, Endear will likely have to integrate with one of these services that provide some level of this information truly as a way to check the box. I don't want to do it because I think a lot of the information is wrong and it provides a poor member experience. I think health plans will want to give their members some tool to land on just, "All right, if I'm the cheapest vendor, integrate them," which honestly is a poor outcome.

I'd rather not do that. What I think is more appealing is finding you do have the specific centers around the world that are far better at knee surgery or the doctors that are far better at back surgery or a radiologist that don't miss as many things in the scan and really trying to say, "Let's get kind of some of those targeted networks up and running." Walmart has done a really good job with this.

Some of the other large employers have as well about really saying, "All right, maybe we don't know what quality looks like across our entire book of business, but we know four of our cost centers are things that we can direct people effectively for." So I'll just stop worrying about giving everyone the information and just say, "If you have these four conditions that we've seen on claims.

Then you're likely to request this type of surgery or type of this procedure, let's get ahead of that." Or if you do request it, I'll pay you $10,000 for you and your family to go to the state, just stay in a nice hotel, to get the procedure done. Because you're not going to need it done another two years from now. And I'm going to come out $100,000 ahead.

I think that, that world is a little bit more in the middle and feasible in the meantime. Long term, yes, if there's a way to pull structured data that's correct that really shows people what they want and what things will cost, we will do it. I don't think it's feasible in the next three to five years unless something changes that I don't know about.

Tegus Client

I analyze that level one here is, a, we want the member engagement platform that makes it very easy for our members to get all the information that they need, maybe call in and chime in, right, I mean. And I see that before, they provide the staff side, the 360-degree view of their membership, right?

But do they expect you sort of like to do more? So like, "Hey, we want you guys to drive towards in-network, right? Or we want people to not go to the ER, right?" Or so are those expectations that are placed on you as part of what you offer? Or that's more of a level two that they still expect their own member service team channel and those kind of things?

Co-Founder and Chief Operating Officer at Endear Health
I would say the hope is that the vendors they work with are able to accelerate their own internal teams and what they're kind of working on. I believe that they believe they're doing it okay. They could do it better. So anyone they work with, if you want to have the conversation on, "Hey, how can we help out here," they're probably here for it.

For us to come in there without a lot of these integrations built or data that shows why we should be doing it, the expectations aren't there. So we don't really have to worry about it as much. But the one distinction I'll call out here is that it's a lot more challenging for a health plan to do what you're describing in the commercial world than it is in Medicare Advantage.

In the commercial world, you're covering people in all 50 states, which means you have to have a provider network that spans every single square mile of this country and a perspective on who goes to where. In Medicare Advantage, Medicare Advantage is based out of very specific geographic counties with members, besides the snowbirds that don't typically move much. So you're able to really say, "Hey, 85% of my members are going to live within 25 miles of this specific office."

Most of them are going to go to this provider setting already. So you don't really have to worry about people going to the wrong doctors nearly as much. Because there aren't a ton of them to go to. And typically, they're the ones they're supposed to go to. So in general, the concept of steerage is just less of something that people are worried about in MA. I believe that, that will change. And we'll have to kind of lean in. But previously, it's just not as much of a need here as it is in commercial.

Tegus Client
What opportunities do you see in the market that are being underserved, right? So I'm deriving this question from what we just discussed. For example, a hypothesis is, okay, MA plans need to be offered some sort of steerage to make sure that they keep costs low. And from what you just told me, it's like, yes, but because of the hyper-regionality of these plans, it's not a true pain point. What are some of the pain points that you are seeing in the MA space or more broadly that you think are underserved?

Co-Founder and Chief Operating Officer at Endear Health
It's a good question. I would say some of the ones that we're seeing here that are underserved, mental health treatment specifically aimed at seniors is something that mental health has gotten $5 trillion of investments over the past few years. The vast majority of it was aimed at commercial populations or even adolescents or teens. Naturally, a longer lifecycle to regain your investment on them if you kind of put that dollars in early.

We are seeing that it's a huge co-morbidity with the senior population. So members that are able to access mental health services, you're able to get more information out of them. So you know earlier on if they're likely to have a fall, if they're likely to malnourished, et cetera. Some of the push to get treatments done in the home has also been a really effective way, so the DispatchHealths and some of the remote continuous monitoring, where you're able to leave them in their own settings, that's been great.

I think, in general, people are just going to go back and forth on the level of high-touch care that these members need. And what I mean, the amount of concierge services that are effective for Medicare Advantage. I don't know the right answer there. But it does feel like we're probably underserving them. But the final thing that I'll call out is just the aspect of community.

Again, it feels very silly that this is tangential to health. But it is just so intrinsically tied to how long these members will live, how happy they will live and what they're willing to do while they live that when I think about companies like Wider Circle to really help seniors build out their networks around them.

They've seen phenomenal early stage data in terms of really being able to generate returns for the partners they work with. When I think about the Papas of the world, some of that is almost like a paid altruism tourism to go in there in their home and help them out with things. I'm still on the fence about do I think it should be there?

So far, the data shows that it's an effective way to approach them. But there's some part of this forced altruism that I think is kind of uncomfortable to me. I think the Wider Circles of the world seem to navigate that better. Because it really doesn't feel as forced. I'm trying to think about anything else that really stands out to me.

In general, I would just say more focus on gathering data from this population and using it to inform stars. With how much stars can impact the plan's long-term success as you think about hundreds and hundreds and hundreds of millions of dollars from some of these plans that are at risk based at points of relatively arbitrary star rating, it's challenging. And for your peer house plan, you're always worried about it.

But you're confident in saying, "I don't know how to do things differently." I think in general, someone needs to connect all of the things that are happening. And honestly, it's what Endear is trying to do. All the things that we're trying to give to members to a way that actually makes sense with trends in the data and allows plans to be better prepared for how they're going to get paid the next year, which is stars. But ideally, nobody else goes to solve that one, so it's just stars.

Tegus Client
Are you the only player now like in the market?

Co-Founder and Chief Operating Officer at Endear Health
Only player? I would say no. Like the players that you listed earlier, they're trying to penetrate. For the most part, they really haven't seen any success. So I would say that we are the only player right now that is selling a senior-focused platform aimed at MA with the goal of being a data integrator. I mean, there might be one out there that I haven't heard of. But our prediction is that within the next 12 to 24 months, that is vastly different. And we are facing kind of a lot of competition. But for now, it's pretty greenfield.

Tegus Client
How concerned are you of other players popping in? And would you be highly disappointed if that happens? Or do you think there is enough of a market for a bunch of players to be successful?

Co-Founder and Chief Operating Officer at Endear Health
I'd be highly disappointed if it didn't happen. If it didn't happen, that would mean that we misread the market and the need for a service like this. My expectation is that they do come in. We've already seen some of these early-stage partnerships trying to get spun up more from a headline perspective than actually they know what they're doing perspective. I think the market is far big enough to support a whole bunch of different players here.

When you kind of think about that 30 million members in MA and what a good business looks like, if you can even carve out 3% of that, 2% of that and you have them on a few dollars a month PMPM, you've got a really sizable business pretty quickly. And that's really just the front door component, let alone what other services you could tack on to it. So we expect competition to come. I hope that it comes slowly, but I do hope that it comes.

I'm not too concerned about it, simply because if we exist for four or five years and we're not able to sell effectively, that's probably a problem that we're having with our commercialization strategy and not necessarily just the competition coming in from the market. But more importantly, the amount of uphill climate it takes to pull out resources from a health plan to let you get access to their data, to let them build systems on top of things that you're building in a way that if you rip them out.

They're stuck trying to piece it together is extremely, extremely, extremely unappetizing for a plan unless they want to use you long term. So what we've always seen at Castlight and what we saw at Anthem is that selling into the employer world with a member experience solution, engagement solution, every single year, is going to raise $1 billion to create a new company and sell it for free. And you're going to see churn.

You're always going to see churn. In the payer segment, churn rates are very, very low despite a lot of companies not even doing it that well, simply because the amount of work it requires to pull people out and

the fact that pretty much the plan's biggest fear in Medicare Advantage is that they will give their members something.

They will be associated with that something. And then they take it away and members will leave their plan. If you're able to demonstrate value to members at all, that kind of screw that they have to pay you forever, so I think it's on us to really get in, get some data points before the rest of the market comes, show that we can do it and then just ride the wave up.

Tegus Client

I appreciate all your answers and your insights, learned a lot. I hope you have a good rest of your day, thank you so much.
