[00:00:00] Chris Ellis: What I've come to appreciate in the last four years building Thatch is that the most important determinant to how healthcare is delivered and at what cost is the vehicle through which it's funded. And I first learned that lesson right out of grad school. I was a cancer researcher, and my very first job was I started a sales team for a health tech company selling into hospitals and health systems.

And I got to see firsthand. I wanted to get closer to the actual care and what gets delivered, but I saw firsthand that what people choose to purchase and the products that they use, it's not just about the outcomes that you create, it's about how much it costs. And it really started to kind of tune my antenna to this idea that if we can rethink the way healthcare is funded, we might be able to change the way that we access it as people.

[00:00:53] Narrator: Welcome to Inside the Plan, a podcast featuring real conversations with healthcare leaders on strategies shaping health plan transformation today.

[00:01:04] Craig Savage: Welcome. I'm excited to have as our very first guest Inside the Plan, Chris Ellis, the founder and CEO of Thatch. Thatch is an interesting organization. Chris is the brains behind that. And we could not be more excited to launch Inside the Plan podcast with Chris Ellis. Chris, your background is fascinating. I believe if I got this right, your career started in cancer research, which is fundamentally different than where you are today.

And then I believe you moved into technology products. Now you're leading Thatch. What was the inflection point that drew you to the specific problem? What did you see? What did you experience and believe that made you decide that this was a challenge worth dedicating your energy to?

[00:01:50] Chris Ellis: Nobody on our team, probably not in this call, and certainly not me. Grew up as children and imagine one day we'd be in the health insurance space or selling health insurance, and that's what we do at Datch Health insurance, to most of society, like health plans, kind of. It feels like a boring and intractable problem that in many ways is very removed from the day to day needs of everyday people. But what I've come to appreciate in the last few years, four years building Thatch, is that the most important determinant to how healthcare is delivered and at what cost is the vehicle through which it's funded. And I first learned that lesson right out of grad school. I was a cancer researcher and my very first job was I started a sales team for a health tech company selling into hospitals and health systems. And I got to see firsthand. I

wanted to get closer to the actual care and what gets delivered. But I saw firsthand that what people choose to purchase and the products that they use, it's not just about the outcomes that you create, it's about how much it costs. And it really started to kind of tune my antenna to this idea that if we can rethink the way health care is funded, we might be able to change the way that we access it as people. And fundamentally, that's what health insurance is. It's the payment layer for American healthcare. Historically, this payment method has been a defined benefit, something that, for example, an employer chooses on your behalf. But we're moving to a world that looks much more like a defined contribution, where instead of a benefit being given to you, money is given to you. And you can use that money to decide how you want to spend it and how you want to navigate the healthcare system.

And that's kind of the core of what we're helping to enable at Thatch.

[00:03:42] Mike Epstein: Exciting. So, tell us about what your vision for employer health benefits are. The job market is certainly evolving, and there's a mismatch between how people work today and how benefits were originally designed. What does the future look like?

[00:03:58] Chris Ellis: One big change is the fact that people used to spend most of their careers at the same place. So you'd start and work your kind of way up from the factory floor and spend 30 years at the same company.

And that model is starting to certainly change really rapidly. You have the gig economy where you have a very large portion of the workforce that's not under a traditional WSU model and that's getting bigger. You have the length of time an individual stays at their job going down and down and down.

And it's natural to wonder if your healthcare is tied to your employer and you're spending less time at each employer, should healthcare be attached in the way that it is to employment?

And one really excellent analogy to how I think about the healthcare landscape today is actually look at the retirement landscape. Handful of decades ago, it used to be that most employees, when they stayed at the same company for their whole careers, had a pension that was managed by their employer and then they retired. That reward for their long years of service was access to retirement funds directly.

There was a period of time where pension plans became very expensive to manage due to financial macro. Many went underwater. And that led to a shift to 401 s defined benefit to defined contribution. Carrying on this theme, and it actually ended up suiting the modern workforce much better. Because you can take your retirement strategy with you from job to job. We haven't seen that same shift happen from defined benefit to defined contribution in health care, but we're starting to see signs that it might. One big one is the fact that for the first time in the last 15 years, health care costs and trend are going up much, much higher than they have during that time period.

And that trickles its way back to cost pressures for employers and a general openness to reevaluate. Is the way that we're doing it today maybe modern enough for today's workforce? And is there a possibility that if your retirement strategy at 22 is different than your retirement strategy at 60, then maybe your healthcare strategy at 22 and 60 should be different as well? And so those are some of the things that we think about the job market's evolution.

We believe that there's going to be a natural progression towards defined contribution, just like we've seen in many other forms of employee benefits.

[00:06:27] Craig Savage: I really like that fundamental reframing and thinking about it in terms of the way retirement benefits had historically been thought of and that that whole evolution, if you will, what are the first two or three changes you believe would most effectively realign employer health benefits with today's workforce? And how would you measure whether those changes are actually improving?

We all know the AAA, right? Improving access, affordability and outcomes.

[00:06:58] Chris Ellis: In my mind, decoupling health insurance from an employment is the number one way to improve access 40 billion outcomes. And I can talk to you about this in theory, on paper, but instead I'll give you a story.

I was meeting a few weeks ago with Clay Johnson, who was the head of the Dell Medical School.

Incredibly smart guy. He came up with all of these really amazing initiatives that could control costs more effectively, deliver more essentially higher quality outcomes, different shapes of investments in preventive care. It was a real pioneer.

When he went to traditional insurers to get this reimbursed, they said, we don't really understand what you're talking about and this doesn't fit with our fee for service model. So it's not going to work for us now. Undaunted, Clay said, well, I'm going to actually start my own health plan. I'm going to raise a bunch of money and found a company called Harbor Health here in Austin. He bought a bunch of clinics. And what he did with the kind of foundation of his insight was if I can own parts of the care delivery process, I can launch a health plan and insurance that actually has really incredible actuarial value at a much lower cost.

And while we were grabbing coffee, he was telling me how hard it is to actually sell that health plan to employers. And the reason for that, employers want to take care of all their employees. And so if you have 10 people in Austin and one person in Detroit, your local Harbor Health plan doesn't really serve the needs of that employee out of state, or certainly if you go into the middle market or large companies who naturally have employees dispersed all over the country, it's very hard to sell them on a local health plan. And that's why most commercial health plans are Blue Cross, United, Cigna, Aetna, all of them were founded before the Internet. You haven't seen a lot of innovation in health plan design because of the necessity to have a national network to support employers across the country.

Now, when you think about what happens in a world where health insurance is decoupled from employment suddenly in a world where a million people in Austin are. Are on individual plants, it's much, much easier for a Harbor Health to get off the ground. They can grow 10 times faster because they don't have to sell the employer on why it's good for their local population. They have to have a product that consumers demand, and the actual product they have in market, incredibly high actuarial value at a very low cost. And so if you think about what could happen if more of the market was on this model, there would be a million more Harbor Healths all experimenting in their local markets with new innovative plan designs and ways of rethinking healthcare more broadly. You'd also have something that's really interesting, that an individual that chooses that health plan, whether it's Harbor United or whoever, they can then at their next employer, keep that health plan from job to job.

When you think about what happens when an employee is able to have continuous coverage for a period of time that's longer than two or three years for the traditional time frame where someone might stay at a job today, suddenly those health plans have a much longer time horizon to think about recouping the cost of preventive care.

If you can make a member healthier over 10 years or 20 years, and you can keep them during that time, you may invest more upfront in a, perhaps a more expensive intervention or something that has a longer time horizon to think about recouping costs. And so this stuff isn't like science

fiction. The healthcare system that's rated the most innovative in the world, it's Switzerland. And their exact model is a defined contribution. Where the government provides a defined contribution, there's a private marketplace of health plans that compete for the consumer's attention and each consumer can stay with that health plan for a long period of time. So I really fundamentally believe that if we want to recreate that innovation and really align the outcomes towards the consumer, you can't have a construct with a purchaser who the employer is purchasing on behalf of an individual.

[00:11:00] Mike Epstein: It's interesting to hear you talk about ICHRA as kind of fueling innovation in the health plan space and ultimately reducing costs and increasing quality, which is something we've all been trying to do for a long time now. What's the governance and operating model that needs to be in place that would allow an employee to have that predictable experience as they move from employer to employee employer and does the requirements change when you think about different segments of the market, small employers, middle market and large employers?

[00:11:36] Chris Ellis: The consumer experience, regardless of employer is. Size is the same because it's an individual buying a plan where large companies and small companies have different requirements is actually more on the administration side for the employer. Like the automated offboarding and onboarding for payroll roster syncs and employees like those get more complex as you get bigger. But fundamentally, when we think about how you deliver a predictable experience, the core of the solution that an ICRA administrator like us needs to provide is pretty simple. Like make sure people get enrolled in the correct plans, that they stay enrolled and the payments are made timely to the carriers and, and that the billing statement is reflected accurately in the employer's dashboard and they're getting essentially paying the correct amount to each of the carriers.

Even though that sounds really, really simple, Anybody who's worked in kind of health IT or specifically with like health plans, you know that because some of these carriers we talked about are all older than their Internet, so are the systems that power their infrastructure. And that means that a lot of the work that from a governance perspective that like an ICHRA administrator does is not just managing the taxes and the compliance and everything that the employer needs to button up, but it's also to abstract the complexity over the chaos of the healthcare system. And some of the systems that are designed maybe like with not thinking about modern APIs or maybe built on kind of infrastructure that's, you know, ultimately stood the test of time.

So when we think about predictability and quality, a lot of it comes down to reliability.

Like when you bill, it's an accurate bill. When you choose a plan, you actually are enrolled correctly and you get your ID cards and things work. And these aren't sexy things, they're kind of the kind of things you just expect should work. But it turns out that there's quite a lot of technical infrastructure to build all of that.

[00:13:37] Craig Savage: Fascinating.

So we're seeing real momentum in the ICHRA adoption, I think 29% year over year from 2023 to 2024. I haven't heard what 2025 looks like. Where is that growth coming from? Where is it the strong, Is it the small businesses, mid size, privately owned companies? Where and what's driving the uptake in each one of those segments? Chris?

[00:14:01] Chris Ellis: Yeah, I mean certainly I've heard the 29% year over year at an industry level we're seeing over 300% year over year growth at the individual level.

And so much of what we're seeing is across segments. But there's a couple places to call out very large employers who are self funded. Typically they have got a lot of strategies to be able to contain and manage costs. That doesn't make the average larger employer typically a good candidate for an ichra. Where we see most of the demand is in the small to middle market, all the way from a one person solopreneur who like can't even get a group plan because they're too small, all the way up to, you know, couple thousand, few thousand person middle market and everywhere in between.

One of the things that's really interesting in the middle market where you have ales or applicable large employers, over 50 employees, they're in this really interesting spot because they're too small to be really benefiting from self funding because the large, large employers have got large number of employees to spread the risk across, but they're too big to participate in the small group risk pools which are community rated. So all of the businesses purchasing health insurance and the small group market in Austin are part of a big pool that gets underwritten as a, as a big block. So mid market is actually uniquely vulnerable to healthcare cost increases or a single large cost claimant because they're not part of the small group pools nor are they self funded. So we see the variance in healthcare cost increases in the middle market be quite substantial.

In small business, a lot of what drives adoption has to do with local geography. So it's hard to draw small business conclusions on a national level. You have to dive into what's going on in that local market. And it might be that in say Ohio or I just saw last week, Blue Shield of California raised small group rates 12% in Q1, which is totally unheard of.

There are unique factors like the degree of level funding penetration or PEOs, the availability of alternative products statewide Reinsurance pools and the unique regulatory landscape in the state which can make individual versus small group be more leaning in one direction or another.

And so what we find is that the criteria for a business to want to adopt an ICHRA is one, the plans that are available to them are at least comparable or better to what they have available to them today. And that will rule out some employers in some markets. And then two, is the cost comparable or less than what they're paying today? And surprisingly, the individual market, which is 25 million people, has ripped the band aid of the enhanced subsidies off and actually happen to be still quite resilient, is a very stable and attractive pool for a large number of companies. And so we estimate part of the adoption for ichra and the momentum has to do with the fact that there are way, way, way more businesses that economically based on those criteria should be on an ICHRA than are. And our task as an administrator in the broader market is actually just finding them, educating them about the solution and then delivering on the promise of what it can do.

[00:17:16] Mike Epstein: So, Chris, how do you find those employers if that's the biggest challenge you're facing and you seem to have the equation worked out if you're seeing 300% growth. So what's been your, your go to market strategy and what's making you so successful?

[00:17:32] Chris Ellis: We originally grew a lot by word of mouth, so people, oh, I have this great solution and but the reality is kind of at our scale, like you can't grow 100% organically. And

the truth is that for most of the market outside of the first time healthcare purchasers, the customer will, an employer will typically have a broker that's advising them. And so core to our strategy and where we have delivered the vast majority of our growth is by partnering with brokers and kind of acting like the infrastructure and technology layer to help them more effectively position an ICHRA to identify groups that are good fit. And so that ends up being really excellent for us because we can get a lot of leverage out of our go to market by recognizing that, you know, if we have one rapid that who's working with, you know, 50 local brokers, then we're getting access to 50 times the total number of employee employers that you know at each brokerage. Um, and it ends up being a way to get out, get the reach out really effectively versus a lot of companies in the insurance health plan space have tried to go direct and kind of abstract away the broker. And there's a lot of notorious examples of that being a totally failing Strategy. And we've learned from kind of the lessons of history that for a, for a product to really get to market, you need to find a way to align the incentives such that an employer can get value from the solution. A broker can economically justify positioning that solution in their market relative to the other products that they can sell. And that's where I think we've been able to kind of crack the code.

[00:19:15] Mike Epstein: That's great. And I think you're right. You need to work with the broker because they have the connection to the individuals and to the employers, and they're definitely an integral part of the delivery of health insurance today.

So, what can an employer expect as success at the end of the first year of moving to an ICHRA?

And what metrics or how should they look to assess whether or not their transition has been successful?

[00:19:45] Chris Ellis: It's a great question. So typically, in order to gauge a truly successful transition there, there's just how on the upstream side, I mentioned that, like, is the quality of the coverage comparable and is the cost comparable when you look downstream, then how do you measure that from an employee experience and from a P and L perspective? And so typically, what we've seen is an employer will do a survey right before they make the transition on how they would rate their existing benefits. And then immediately after or six months later, they'll do a similar survey with the same questions about the new plans that were offered to them. And typically, what we find is in every case, whether you're switching from United to Cigna or you're switching from Blue Shield to an icra, you're going to have some people who are neutral, some people who are, this is way better, and then some people, this is way worse.

Our gauge for success is that you typically want to see the window move in the right direction where there are fewer detractors than there were before and there are more promoters. And really there's that consumer experience, which is kind of at the heart of where we believe, like, the technology ultimately has to deliver on that. That feeds back into the business model quality. For us, when we think about retention and churn and how we keep employers, it doesn't just come down to the bottom line, which, of course, that's the easy thing to measure. Are you spending more than you did, you know, than you were before, or less? But we, we typically, if we're doing our jobs correctly, solve that problem. But we. Before you are implemented, but we still measure that as a success criteria. But the truth is, like, if an employer wanted to save money, they can simply put more cost sharing onto their employee and not switch plans. Right. So when you're moving to an Ichra or any kind of alternative health plan or any new carrier, whatever it might be, the really, really important thing is not just can I save money? Obviously

that may be a core input to the equation. With health insurance being the biggest line item after salaries and most P and LS like the money matters, but the consumer experience, the employee, that's really, really critical.

[00:21:48] Craig Savage: Looking ahead, Chris, over the next 10 years, I mean, you've painted a really interesting picture, especially for the middle market. But how do you envision health benefits experience for the typical American worker evolving if ICHRA really continues to grow, especially at 300%?

[00:22:07] Chris Ellis: So we talked a little bit about decoupling insurance from employment, but there's something that is talked about far less that I think is actually just as interesting if more, which is the idea of decoupling insurance from non catastrophic care. Okay, what do I mean by that? So think about your car insurance. It covers you get into an accident and busted your fender. It doesn't cover oil changes, it doesn't cover routine things. Yet in health insurance we've grown accustomed to a model health. Health insurance serves as this prepaid expense card that covers everything. Oil changes, fender benders, car totaled.

And as a result, whether it's catastrophic or routine, anticipated or not, we've essentially created a system where all of the money in America that flows through healthcare, which is 20% nearly of GDP, which in context 1 out of $20 spent on Planet earth goes through this monolithic system that is an administrative layer that pays for all health expenses in America.

Now what would happen if health insurance actually was insurance? I'll give you an example. So here in Austin, there's a dentist called Swish Dental and I really enjoy it.

They care about delivering a great service experience.

They have a brand that resonates with me. It's very easy for me to like shop for the prices of the things the crown. I can compare it to other things and it actually is not the cheapest option on the market. But when I go in there, I know they're going to do a good job. And I feel really good about like the feeling I have being treated like a customer. And I feel like a customer when I go to the dentist, I don't feel like a patient.

This founder is a friend of mine. They are expanding actually to more sites in Texas because the model is so successful.

Why am I talking about dentists when we're talking about medical insurance? And the American worker. The reason is that the dental model is one where most of the services are cash pay. You might have dental insurance, but it's like a dollar for dollar thing that's not actually covering you for like catastrophic dental things that, that's kind of where that that might happen. And the truth is like most of the things you pay for when it comes to your dentistry outside of your, your teeth cleaning tend to be something that you know might be $1,000, 5,000, whatever it might be.

But in this model, dentists, which are health care professionals as well, just for a routine service, they're notoriously have much higher nps, much higher service, much more transparency in their prices. They advertise to try to reach you, the customer. But in the American healthcare system for medical professionals, we aren't treated like customers, we're treated like patients. You walk into any routine service and you notice that you aren't greeted like hello, welcome to this place. We would love to deliver you this great service. Can I sell you on getting this or that? Because

you are not the holder of the purse strings. It's your employer, it's your insurer and maybe a government payer. And when the customer is an insurer, they're the one that's get treated like a customer, not you. And that's why going to the doctor feels unlike any modern experience.

In a market driven economy, there's no incentive to publish prices, there's no incentive to publish quality scores or compete on quality. There's no incentive to modernize the technology stack. There's no incentive to treat you with the level of customer service that you might expect from your barber or your car dealer. Because they don't need to do any of that to win your business. Because it's not your business, it's somebody else's. It's your insurers. And you have to deal with it whether you like it or not.

How do we solve that problem? We'll come back to what we talked about at the very beginning, which is define contribution. Define contribution is not simply let me choose my insurance. It's actually something that's a far more powerful concept which is let me decide how to allocate the money that I'm offered on an annual basis between insurance and my own consumer purchasing goals. So if you have a thousand dollars a month in an ichra, you don't need to spend it all on insurance. You can spend $500 on insurance and you can spend the other $500 on whatever you want.

The vision that we Have. And where I think it gets really interesting is when that remaining $500 can actually be stored in perpetuity by the consumer and can actually start diverting the flow of funds away from insurance and into consumer accounts that they can own and spend down for health expenses. We enable some version of that today, although the rollover is only on an annual basis. I get excited about what can happen if you can roll the funds over on a longer than annual basis or perpetual basis. Because when you think about it, imagine if 20% of the $2 trillion we spend every year on health insurance went to consumers instead of insurance companies. In five years you'd have the consumer spending power to pay for all medical services in the country in cash.

And if you think this is a crazy concept, you should look at Singapore, which has 10 year longer life expectancy than the US above a 90% average rating for the quality and costs and everything of care. And they also have a model where insurance only covers non catastrophic care. The rest of the funds actually go to consumers. And by the way, economists call this impossible. Only 5% of their GDP is spent on healthcare relative to R20.

And so although we may not be able to wait around forever for the government to come up with the optimal construct to allow all this to happen, I do believe that under the defined contribution model, with a technology company like Datch, we can create the scaffolding to allow consumers to have the purchasing power to thus change the industry. Because if every consumer actually had enough money in their account to pay for healthcare to actually cover routine services that may be $20,000, $30,000 and are actually conditioned and expensive expected to do so, you would start seeing routine healthcare providers start advertising for. You can get a great deal on this MRI here. They would have an incentive to publish the prices when you walk through the door. They would treat you like a customer. And when I think about long term, 10, 20, 30 years, in order to have a society where our children will be able to afford health care, where when we're old, Medicare is not defunct, we have to introduce market forces into health care and allow consumers to be able to spend more efficiently.

[00:28:42] Craig Savage: Wow. Wow.

Very, very interesting. So Chris, like I'm walking away with ICHRAs as a pretty important inflection point that offers a lot of potential change, a lot of like really attractive change in the marketplace from a defined benefit to a defined contribution really puts more control in the hands of the consumer and I think more accountability in the hands of the consumer for their own health and well being, not just the services they get, but it provides a real incentive for them to think about their health and wellbeing and the money that's being given to them to take care of themselves. Really exciting, really exciting opportunity here.

[00:29:26] Chris Ellis: We're super excited about it, too. Every few decades, healthcare costs go up a lot, and it creates a window for movements like this to take hold. And we certainly believe that we're entering into one of those moments now.

[00:29:40] Mike Epstein: Chris, this, this has been a super enlightening conversation. We really appreciate your time and wish you continued success.

[00:29:48] Chris Ellis: Well, thank you so much. Thank you for having me.

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