Talks at GS
Kate Ryder
Founder & CEO, Maven Clinic
Kim Posnett, Moderator
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Kate Ryder: I want to be able to show up to every person who is thinking about starting a family or in those early years of building their family and we're showing up in the way you need us to show up.

[MUSIC INTRO]

Kim Posnett: Welcome to Talks at GS. I'm Kim Posnett. I'm the Global Head of Investment Banking Services and the Co-Head of One GS. In partnership with our Women's Network and in celebration of Women's History Month we wanted to have Kate Ryder join us for our GS Talk session.

Kate is this real trailblazer for women in the field of healthcare and has been amazing. And we've gotten to know each other over the years. Kate is the founder and CEO of Maven. It's the largest telemedicine network catering to women and families. She's been featured and

Fortune's and Crane's 40 Under 40 list. She was in Fast Company's Most Creative People list. And then Maven was also set as Fast Company's 50 Most Innovative Companies. And that was last summer. And last summer, Maven also became the first female-led telehealth startup to attain unicorn status, which is a huge deal. So, welcome Kate.

Kate Ryder: Thanks so much for having me.

Kim Posnett: Of course. Okay, so why don't we just start with the background and elaborate a little bit on Maven's mission? And we'll go from there.

Kate Ryder: Great. So, I started Maven eight years ago. It sometimes feels like 20 years. And sometimes it feels like eight days depending on the day. And at the time, the whole care model as it relates to women's and family health felt like it was really stuck in the 1980s. Some parts of it very much still do today. Where, you know, a woman had a baby. She may or may not have gotten support during recovery. And then she went back to work. And that was what building a family was.

And so, if you think about that model, there are a lot of things that are left out of that picture. So, things like fertility, right? The fact that one out of eight couples suffer from infertility. Or the fact that when the LGBTQ community wants to start a family and they want to adopt or go through service [PH] or go through IVF, none of that was baked into the care model.

And then when you think about things like postpartum depression or the fact that 43 percent of new moms drop out of workforce after having kids, clearly there is a lot, much to be desired. And so, that's kind of what the macro looks like.

And personally, a lot of my friends were just starting to have kids at that point. I have three kids of my own today. But you know, so when one of my best friends first started the family building journey, she got really bad postpartum depression. The next friend couldn't conceive. And it took her three IVF rounds.

And so, for me, I was working in venture capital at the time. And I was very much kind of trying to figure out-- I

knew I wanted to start a business. All of the personal stories and all of the just massive inequities were so glaring. And so, I thought, you know, sitting from across the table looking at all these entrepreneurs starting digital health businesses, I thought, wait a second, why are there no women coming into these rooms? And why isn't anyone focused on this moment of building a family, because it's so central to a functional healthcare system?

And so, very boldly and brashly I thought, well, we're going to figure it out and do it. And I think knowing what I know now, I'm so happy I know what I know now about how hard it is to innovate in healthcare.

Kim Posnett: Maybe talk a little bit about your prior life as a journalist, because I think we should start there because it's very instructive to how you built the business and how you approached things.

Kate Ryder: I was always a business and financial journalist. I worked with *The Economist*, *Fortune*, *The Wall Street Journal*. I worked in London.

Kim Posnett: *The New Yorker.*

Kate Ryder: *The New Yorker*, yep. And so, you know, the way I think my strengths always were in journalism were telling a story, right? I loved meeting people. I'm very extroverted. Just really, really understanding a story.

So, I would do things like I would show up in, when I was in Singapore, one of the cover stories I wrote for *The Economist* was social media in Indonesia. So, I kind of go to Jakarta. I knew nothing about that. And then meet a lot of different people. And so, that was very much how I approached Maven.

And so, with both I had my own, of course, personal experiences and the stories of my friends. But really went out and talked to at least 100 people, mostly women, around what it took to start a family. And then same thing on the provider side. I talked to about 30 different women's health providers from doulas to OB-GYNs to pediatricians and was like, "What's broken here?"

And one of the big questions I was asking them is like, so,

all of this telemedicine is starting and, like, why aren't you guys doing telemedicine? Why is it only primary care? And everyone was like, "Well, I don't know. Because that doesn't make any sense." And this is, particularly, when you looked at some of the early digital health companies and the consumer of those products was disproportionately women, why in earth weren't we actually bringing in providers who catered to women in so many of these platforms? So, that was kind of resoundingly, like, wow, a huge signal that Maven was the right idea at the right time.

Kim Posnett: You mentioned a couple minutes ago like separating signal from noise and seeing signal in the noise. Talk about that process, what you learned from being a journalist, how you apply that to running a business now. What does that mean to you?

Kate Ryder: Yeah. So, I think one of the jobs of a CEO of a scaling business is that, and you know, I feel like my job over the years has definitely evolved. And so, right now specifically, we have a really fast-moving market. So, five years ago my job was like evangelism 24/7 because a lot of people didn't know the problem. Everyone knows the

problem now. Everyone's buying. We've never seen such commercial traction.

And so, I feel like my job really is to almost be that, what is it, like a lightning rod that I collect all of these different things and then you look for the patterns and you look for the data and you follow the data. And the data isn't just the numbers. But the data is stories that people are telling.

And so, if something keeps coming up or something keeps coming up and then it's something maybe we heard five years ago from one of our patients or providers, then all of the sudden you kind of take that thread and you follow it. And you then start proactively asking the question.

I'll give you an example. Menopause. Menopause is coming up a lot. It started to come up two years ago. And yet, I would proactively ask our clients, our members, what do we want to do here? And now I think we are going to be launching a menopause product in early 2023 because all of the sudden the signal got louder and louder and louder. And then with our client advisory board where we have some of the biggest companies in America on it, they were

like, "Yes, I will buy this. Yes, we are hearing this disproportionately from our membership now."

Kim Posnett: So, let's talk for a second about fund-raising because you've scaled this business also through a global pandemic. But talk about what it was like raising from investors over the years in the early days. What was the response? How hard was it to raise when you were an evangelist?

Kate Ryder: Yeah, we were two weeks out of cash at one point. But I think in the early days of talking to investors, again, it was 2013/2014 and women's health was considered niche. No one was talking about fertility. No one was talking about miscarriage. No one was talking about postpartum depression or even just how hard it is to be parents of young kids at a time when your career is ramping and all of the trade-offs that come with that.

And so, you know, we started in London. And there was not as much stigma in women's health in Europe. So, a lot of the friends and family rounds that we pulled together very early on, which was about a million dollars, was pretty

straightforward. It was just like a "Hey, I want to see more traction," or "Sure, I'll give you $50,000. It sounds like a good idea." And I had had a network, obviously, from working in venture capital.

And then moved to the US to try to raise an institutional seed round and it was just like a blood bath. And it wasn't about show me more traction or don't, you know, or here's a little bit of money and the valuation's good enough. It was like, "Pelvic floor? What is that?" Or like at one point someone was like, "How do you have so many men working for you? This is, like, women's stuff." It was sad, I thought. It was like really sad because even my most conservative male family members who I would show these early pitch decks to with all of the economic argument around women drive 80 percent of healthcare decision making. Healthcare is almost 20 percent of GDP. There's big business here. And it's underserved and it is so ripe for innovation. My most conservative family members who, like, really didn't understand women were like, "Yeah, that sounds like a good investment. That sounds like a good business."

And so, I was like, what is wrong with this venture capital

market that they don't see this? And then you look at the returns of venture capital as an asset class and, you know, I was feeling better at night. But then I think really what it took was more female investors coming in.

I spoke to individual female angels, but in those early institutional rounds what would happen is I would meet a wonderful man, a male investor, who would see it. He was a dad. He got the problems that we were solving. Then he would take it to his partnership and there wouldn't be a single female in the partnership. And so, we would get rejected because someone would be like, "There's no problem here. Women have doctors. There's no problem here." And so, that was our series A after, like, 40 rejections, was led by a mom of three who was pregnant at the time, and she had a very small partnership. Was a very small B to B fund here in New York. Spring Mountain Capital. She was like, "Guys, this is a big market. Look at their pipeline. Look at the rest of the trends in digital health. Like, we should take a bet here." And she convinced them.

Our series B was led by two women's, Jess Lee at Sequoia

and Nancy Brown at Oak. So, they co-led it. Our series D was just co-led by a woman, Deena Shakir. And so, through the years, I think it really has come down to, you know, we talk a lot about our products trying to help gender representation at top of corporate America. But VC has also had a big problem. And so, I do think Maven would not be here today if there weren't more female investors that finally were getting seats at the table. I mean, we have a long way to go, but you know, at least there is some progress.

Kim Posnett: You started D to C. And then I think over the years, you largely operate as B to B. And I think you recently announced a big partnership with Microsoft, and you've got five of Fortune 15. And so, it's like huge strides. Can you talk a bit about that?

Kate Ryder: What we always say is, like, you know, to innovate in healthcare we definitely believe that you have to innovate from within. You cannot innovate by just staying on the outside of a very big, complicated system. You have to kind of get into the guts of it to really make change. And so, the change that we're trying to make is we're trying to

bring better healthcare to underserved and marginalized patients, whether that's women, or whether that's the LGBTQ community, whether that's children.

And so, the first thing we had to do as a business to kind of get all of this done and really kind of march towards this more [UNINTEL], I really think we're about 5 percent of the way into our journey, is go D to C.

The idea there was like we had to kind of prove to ourselves and to our members that our product works and that consumers actually liked our product. That they were getting value out of it. Because how could we sell anything to a company if we did not know that actually our product was good? So, that was kind of the first layer, so to speak. It's like peeling back an onion.

Then the second was employers. So, the next thing we did was, like, okay, employers. Employers would buy this. The psychology of our membership is that they want healthcare for free. They want someone else to pay for it. The employers are in the best position to buy because employers want happy, healthy employees. They want

women to come back to work after having babies. There's a whole business ROI that's attached to our clinical ROI as well. And so, we started to go to employers.

And at the time, in 2016 and 2017, so, there were actually markets in adjacent areas to women's and family health. There were, like, well, maternity costs are clearly one of your top costs. You have this whole return to work problem. And so, you know, happy, healthy employees for you, that's what we're trying to do as a business. So, it all worked.

The health plans are so important because not only do they work with the employers, so it's a nice channel to sell into the employers, but then they work with populations like Medicaid. So, another kind of sad statistic in our market, our market's actually very joyful because lots of people have babies and that's a great thing, but is that one out of two babies are born, nearly one out of two, on Medicaid. Medicaid is healthcare for lower income America.

And so, for us, you know, employers are like half of the market. But the other half of the market is Medicaid. And

so, to be able to now use the employers to say, look, we have clinical outcomes. We have business outcomes. All of your clients who are also employers want Maven. So, you should partner with us.

And so, now we have some of the biggest national health plan partners. We can't publicly talk about them yet. But you know, coming. But then let's work with your commercial populations that now Medicaid is the next step. So, we started with D to C. Then we went to the employers. Then we went to the health plans. We were working with the commercial side of the population. And now we just launched our first Medicaid populations this year.

Kim Posnett: So great. Just for the audience, explain a big part of the vision and strategy is the transition for fee for service, like the fee for service model to a more value-based model. Maybe spend some time on explaining that.

Kate Ryder: The way the healthcare system is set up is that, you know, the more surgeries you do, the more money you'll make. And so, the way it kind of comes back in women's health is that it's better business to do a C

section than to have a woman do a natural birth. Or it's better business to put a baby in the NICU for more days, which you know, of my three kids my daughter was in the NICU for two days. It was, like, horrifying as a parent to have that. But it's better business. Did she have to be there for two days? I don't know. Maybe it was one. Maybe it was none at all. You know? She was actually totally fine. And so, that's not great. Those incentives are not aligned to driving healthy outcomes.

So, the buzzwords of fee for service to value-based care, what that means is all of the sudden the incentives change where it's actually you just want to do what's right for the mom and the baby in these areas. So, if someone doesn't need a C section, don't do the C section because you're going to get paid the same amount. So, you have a fixed amount of money, and you have to manage the care to the best outcome. And so then, when you have that incentive, all of the sudden you're like, okay, how do I use technology to better manage the care? Should I have more virtual visits? How do I use technology to actually better understand the underlying risk of my population? Because, you know, if I'm a relatively healthy individual and the

person next to me has a history of diabetes, they should probably be getting monitoring that I don't need. But the way our health system is set up today is that I would get the monitoring. They would get the monitoring. Everyone gets the monitoring. And it's just not a way to manage any kind of healthcare.

And so, I think the reason is we are in a public/private system. When you look at a lot of the public models in other countries, they don't have these runway costs. And you know, our healthcare costs continue to rise. So, something has to happen. And one of the things that we always talk about is like to be an endearing healthcare business today, at the end of the day you can create a great member experience. You can improve all of that. But you have to drive costs down because the costs in American healthcare are just too inflated.

And so, for us in maternity, value-based maternity contracts are a very obvious way to start to drive better outcomes. But then also take the costs down.

Kim Posnett: So, let's overlay now COVID. Oh, that.

And, you know, I've talked about this a lot in the context of technology, but its unbelievable accelerating pace of change and new company creation that's been happening for years. COVID massively accelerated that. Accelerated behaviors that were already transitioning, but also new behaviors came out of COVID in terms of digital adoption. Telemedicine was a huge beneficiary of that. But you know, you've been building this business long before COVID. Did you feel like you were better positioned to handle it? Did you feel like you had an advantage?

Kate Ryder: Yeah, so much of entrepreneurship is timing and luck. And sometimes it felt in the very early days of Maven we had not timed it well. But when COVID hit, we clearly had timed things well because we were able to kind of step up.

I remember, I mean, I think all of us, everyone has their stories from March 2020 and April 2020 and May 2020. And so, for us, it was that COVID hit. We had the largest women's and family health telemedicine network in the country. We were known for that. Pregnancy was disproportionately hit because if you guys remember, you

know, partners weren't allowed in the hospital. Women were not being seen in their OBs because there were no PPEs. And everyone was worried about getting the virus. Fertility clinics were shut down. Pediatrics, people didn't want to bring their kids in, particularly really young kids. And so, overnight everything was transformed. And also, like, from a Maven standpoint, we all just went remote work.

Kim Posnett: People stopped going to the doctor.

Kate Ryder: Yeah, people stopped going to the doctor. Period. And then we as a business, like, we all shifted to remote work almost overnight.

And so, the first thing, A, we just started seeing a massive increase in our telemedicine uses. But then we started to get, like, the State of Massachusetts was, like, "Maven, can you do our pediatrics and our OB virtual care appointments for our Medicaid population?" And they were like, "Can you launch in two weeks?" Okay. And so, that was actually one of the most vivid moments where we had all shifted to remote work. And we just had an incredible

team that stayed up like every night for two weeks and we launched it on time, and everything went well.

And then it was also so cool because the providers themselves just started setting so many more hours than they'd ever set because they wanted to work. So, our platform was also just a vehicle where the women's and family health providers could step up and support. And so, that was one of those moments where we were exhausted, and I think quite frankly on a personal level, everyone was kind of scared and people lost their childcare. There was no school. But our team rallied in a way that was, like, wow. I was just so impressed and proud to lead.

Kim Posnett: I want to talk about inequities in healthcare. I'm going to share with you guys some statistics which are stunning to me. I did not know this but the US ranks among the worst in maternal death rates in the developing world.

Kate Ryder: The worst.

Kim Posnett: The worst?

Kate Ryder: Yes. In the developed world.

Kim Posnett: Okay. Let's talk about that. There are no OB-GYNs in half of all US counties. Seven million women live in maternity care deserts. You have to explain what that means. And our national C section rate is 20 percent higher than what the World Health Organization recommends. And so, like, talk about all of that and just explain to us why is there such a gaping hole in healthcare in women's health?

Kate Ryder: Yeah. You know, our chief medical officer, one of the things he always says too to really kind of highlight these points is it's more dangerous for me or any of you who are kind of having kids right now to have a baby today than it was for our mothers. And that is sad.

And so, you know, a lot of things go into this. Number one is, I would say, the health inequities and the poverty in this country, a lot of the really bad statistics are in the Medicaid population. We've gotten poorer. And who does that impact? I mean, it often impacts mothers, right, and young

children. And so, when you look at, for instance, maternal death, one of the really sad things about that is that for a while no one was talking about it because they were only measuring the death at actual labor and delivery. But there's a lot of maternal death that happens maybe four months after you have a kid because you have some kind of hemorrhage or something happens and it's not attributed as, oh, this is labor and delivery, this is childbirth. And so, it was undercounted for a really long time. And still in some states, I'm sure, is. And that, I think, does go back to a lot of the racial disparities in care. That is disproportionately hitting the Black community. And it's because of a lot of the systemic racism.

I think that you see in the healthcare system there are some really good documentaries, our chief medical officer was just in one, about exactly this crisis. That's a big area. I think a lot of it goes back to coverage. So, in Medicaid, and this is just crazy if you think about it, after you have a baby, you're like kicked off healthcare. Sometimes immediately. Sometimes 60 days later. Like, so you have a two-month-old and all of the sudden you are uninsured. What we talked about, obviously, in this fee-for-service

model where it's better and more kind of cost effective to do a C section. At hospitals, I think childbirth is the number one reason for hospitalization. They make one out of four dollars from moms having babies. And they make money when they're C sections. I think in a lot of rural America, there are not OBs. There's a huge OB shortage. And so, a lot of people might be delivered by a family physician in some of those towns. And then if something serious happens, either they just kind of hopefully survive it or they do get kind of moved to a hospital in the bigger cities. But that might be too late. So, there are huge gaps there.

I think there are also huge gaps around getting all of the holistic care around it and the appropriate preventive care during parental care. So, if you live in rural America, are you going into all of your visits? Maybe not. And so, could we be catching things during those visits to prevent adverse outcomes later on? I mean, there is just a whole host of issues here. And I think the way in which a society treats its mothers and children, I think, is a reflection of its societal values. And so, I think now that we're having these conversations about everything from gender to race to health equity is actually showing up in a lot of our

conversations with payers, hopefully that means that we're going to get better on a lot of these fronts. But it's been pretty abysmal.

You know, two steps forward. One step back. But I do feel optimistic that we're finally having the conversations and some of this will start to change.

Kim Posnett: So, you mentioned earlier sort of downstream maternal outcomes. Talk about how your model is helping crisis prevention, lower C section rates, NICU admission rates we talked about, higher return to work rates for women who are new mothers. And talk about sort of this forced multiplier effect of preventive care.

Kate Ryder: We've really been excited about a lot of the clinical outcomes that we're seeing. We're finally at a point where, you know, we have a lot of Fortune 50 clients that bring big populations that now we've been able to measure through claims what outcomes are we driving. And so yeah, we're seeing about a 30 percent reduction in NICU admission rates. We're seeing, depending on the population up front, but a 10 to 20 percent reduction in C section

rates.

I think one of the stats that our chief medical officer is most excited about is the fact that, on average, about 5 percent of pregnant women were receiving mental health care on Maven. A third of our users are using mental health. So, you know, again, just bringing mental health and maternal mental health particularly into the care model. So, you know, I think in a short amount of time we're really excited about what we're seeing.

our scientific advisory board, which are some of the best doctors in the world here in New York and San Francisco and LA, we just had a wonderful scientific advisory board meeting two weeks ago where we were showing them some of our outcomes and they were like, "Oh my God." And so, I think, again, there are so many amazing docs inside the system that are like, "Oh, if we could just solve this problem." And I think technology can help solve the problem. And so, you know, really, really excited to bring it all together because, really, women's and family health is so much farther behind than other parts of healthcare because of a lack of investment for so long.

Kim Posnett: So, I think it's obvious to everyone in the room that you lead a highly mission-driven company and we've talked a lot about just sort of the joy of being part of alleviating the struggles of women and mothers broadly. Tell some stories of patients who you've touched on how they've inspired you.

Kate Ryder: I'll give you one of the earliest ones. This actually has nothing to do with having kids. It's a college student. But it was one of the moments where we were not sure if Maven was going to make it. I think we were, like, 12 people at the time. We were literally standing in Washington Square Park. This is, like, 2016 with clipboards like, "Hey, do you want to try this new product?" We had this beautifully designed postcard.

And so, this young girl who had just started NYU had come over. She used Maven. And she was also really cute, and she was also telling me how, like, she was from California, and she was so nervous about birth control. And [UNINTEL], "Oh my God, here's my phone number if you need anything." And she texted me that night and she was

like, "Thank you so much. I was so afraid to go to Planned Parenthood. But I got birth control from Maven. And I shared Maven with every girl on my college floor." And we wrote them all birth control prescriptions.

So, that was one of those moments, and I had just been rejected by, like, five investors that week, and that was one of those moments where, like, this matters. You know? And we're doing something that works and so we're going to keep going.

A lot of women talk about being misdiagnosed with PCOS or endometriosis who are just not getting the diagnosis. And so, there was this one woman. And there's a beautiful video about her now where she was diagnosed with PCOS. And she wasn't getting pregnant. And so, she worked with someone on Maven, a fertility awareness educator who put her in touch with a nutritionist and a mental health provider. Said, "Why don't you just try this routine for the next few months?" And she got pregnant naturally. She didn't even have to go through IVF. And that was definitely not what her REI [PH] was saying. And then we helped her manage a very high-risk pregnancy. And she had the baby.

And to help someone avoid a highly invasive procedure and get pregnant naturally and then help them manage that pregnancy, you know, I think there's so much more of that that's needed.

Kim Posnett: You have said many times that the world needs more female entrepreneurs. Right now, I think less than 3 percent of venture-backed startups are founded and run by women. So, what needs to happen to drive that? And what's the best advice you would give people in this room, or aspiring entrepreneurs, from an entrepreneurship standpoint, specifically for women?

Kate Ryder: Yeah. I would say just get female mentors around you. There are more and more of us. And just do it. Just keep going. I think that the pools are changing. There are more female angel investors. There are more female venture capitalists. There are more female entrepreneurs. And so, you know, learn from our stories. Build the networks. And, you know, go for it.

Kim Posnett: And let's on this and, like, what's your vision for Maven? What's the next ten, 20, 30 years look

like?

Kate Ryder: I think it was the answer around I want to be able to show up to every person who is thinking about starting a family or in those early years of building their family, and we're showing up in the way you need us to show up. And that's very simple. But there's a lot of personalization in our tech and a lot of partnerships with local provider systems. But you know, that you can come to Maven and we'll always kind of have the answer for you or be able to direct you to the right place.

Kim Posnett: Kate, thank you so much. Awesome. Thank you.