A NEW PRIMARY CARE CONTINUUM

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The Presentation Summarized

- Deductibles have grown and will continue to grow
- The presence of deductibles alone is a market segmenting force; that is, the very sick quickly meet their deductibles and become price insensitive while the healthy and the not so sick remain price sensitive
- There is stability regarding who is chronically sick versus not
- There is nothing on the horizon to change the trend
- The price shoppers will drive delivery system change
- This includes the development of a new primary care continuum of care which includes urgent care, retail clinics, telemedicine and a special form of concierge medicine
- Important to consumers will be pricing information helping them to choose among providers
- There are also implications for provider financial operations as self-pay source of revenue increases as share of total patient revenue

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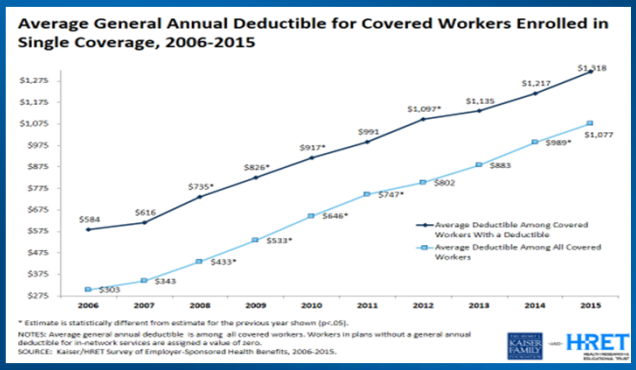
Average Deductible (Among All Workers) Is $1,077!

- Trend is towards more self pay is unlikely to change
- Predates Affordable Care Act



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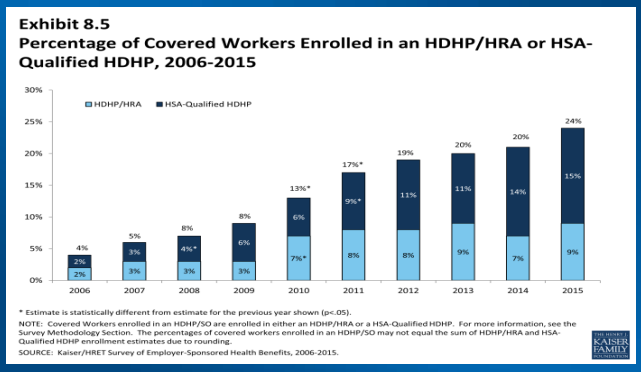
High Deductible Health Plans Are Growing And Now Account 24% of Market

In 2015, High Deductible Health Plans (HDHP) have annual deductible of not less than $1300 per individual and $2600 per family.



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Two Market Segments Will Emerge

PRICE SHOPPERS	QUALITY SHOPPERS
Healthy and not so sick patients who select basic coverage and whose deductibles are frequently not met are more price sensitive	Sick patients who are often chronically ill that select rich coverage and whose deductibles are quickly met are less price sensitive and more focused on quality

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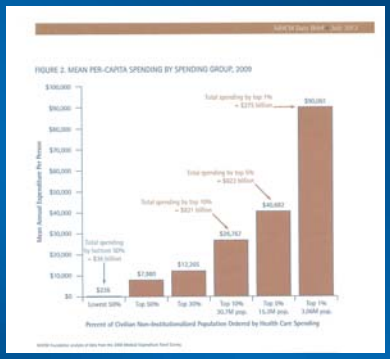
Top 10% Of Population Account For 65% Of The Spend

Price Shoppers Account For 90% Of The Population
And 35% Of The Spend



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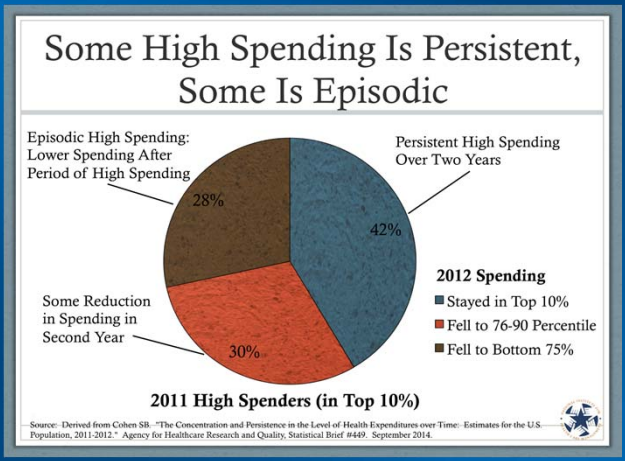
10% Of The Population Are Quality Shoppers (High Spenders) And 72% Are Consistently In That Segment



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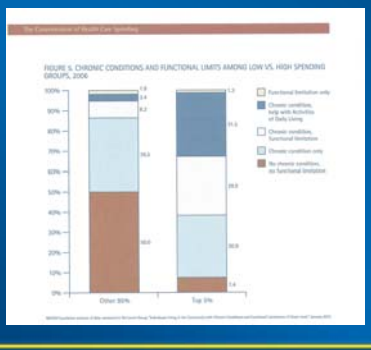
The Quality Shoppers (High Spenders) Know Who They Are

30 percent of the high spenders had at least one chronic condition but no functional limitation, another 30 percent had both a chronic condition and a functional limitation and another 30 percent had chronic conditions and were so limited functionally that they needed assistance with one or more conditions of daily living



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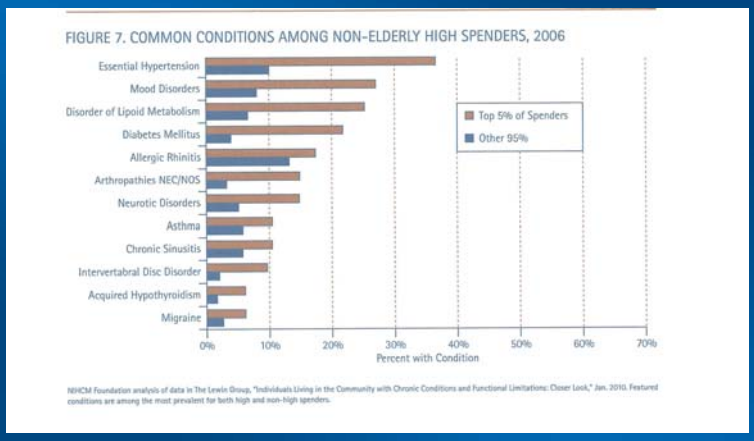
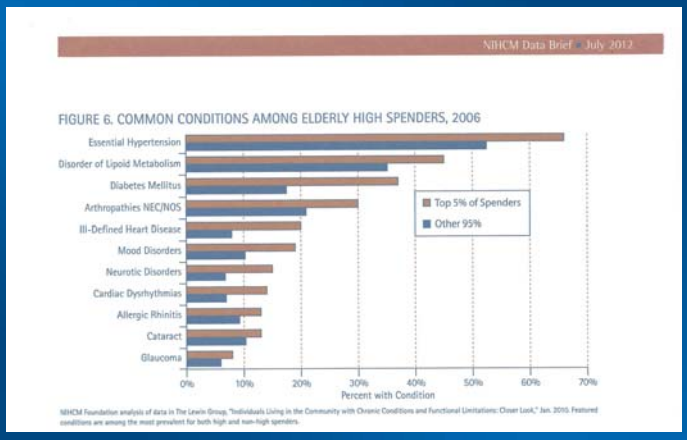
Based On Condition Patients Also Know That They Will Be High Spenders, Especially For The Non-Elderly



Based On Condition, Some Of The Elderly Also Know They Will Be High Spenders



It Is Unlikely That Consumerism Trend Line Will Change Despite Dissatisfaction With ACA

Conventional wisdom suggests status quo will not change; that is, most consumers will have increasing levels of cost sharing at point of service.

The Affordable Care Act (ACA) will not change despite a lack of support from most of the public.

Date	For / Favor	Against / Oppose
7/22 - 10/4	42.0	49.8

Source: Real Clear Politics

It is here to stay because of the low likelihood of unified single party control of the White House, Senate (with 60 votes) and the House of Representatives.

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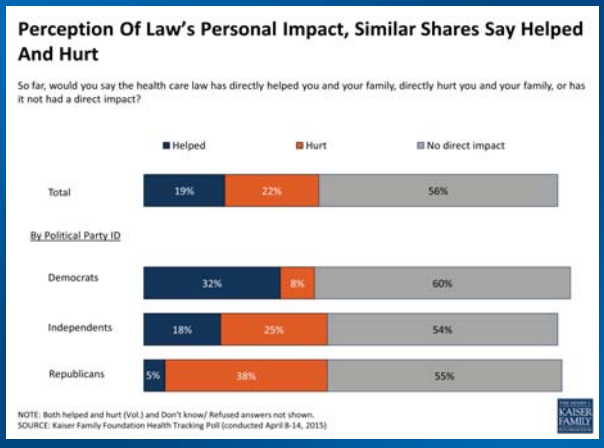
This Is Also Despite 78% Saying That The ACA Has Hurt Or Not Impacted Them or Their Family



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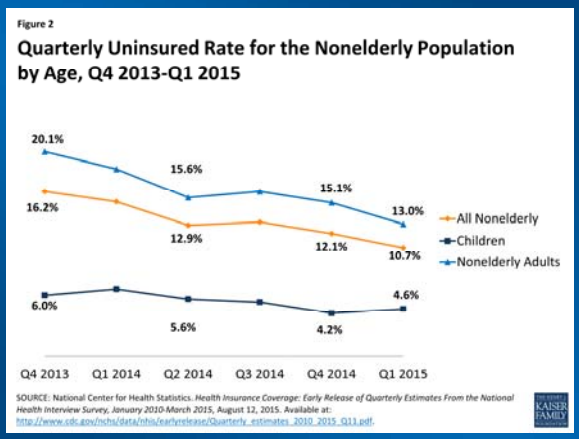
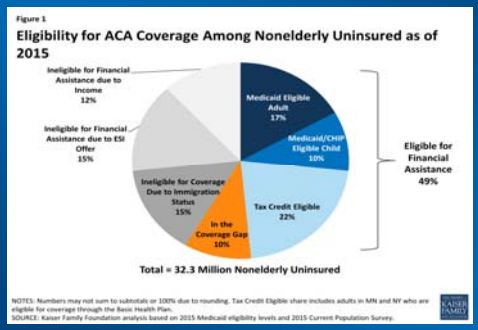
Percentage Of Population Insured Has Increased But Seems To Be Leveling Off



ACA Has Reduced Uninsured By 16.4 Million

Nearly Half Of Remaining Uninsured Are Eligible for Assistance



Original Exchange Enrollment Forecast Is Not Likely To Be Met

Month	HHS Expected Enrollment	CBO Expected Enrollment (March 2015 Forecast)
December, 2014	6.3 M	
February, 2015	11.7 M	
March, 2015	10.2 M	
June, 2015	9.9 M	
December, 2015	9.1 M	11 M
December, 2016	10 M	21 M

Source: New York Times, September 12, 2015 and October 11, 2015; CBO Insurance Coverage Provisions of the ACA, March 2015; March Effectuated Enrollment Consistent with Department's 2015 Goal, June 2, 2015

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This Is Also Despite Increasing Individual Penalties For Those Not Having Insurance And For Low Income Having Subsidies Available

There are 10.5 m uninsured eligible for coverage through marketplaces

- 40% have incomes from 139-250% of FPL ($34-$61K for family of four) and are eligible for APTC/CSR*
- About half had less than $100 in savings
- Almost half are 18-34
- 1/3 are from minority groups (19% Hispanic, 14% African American, 2% Asian-American)
- Penalty is generally not large enough to motivate enrollment (1/10 of premium)

Source: New York Times, September 22, 2015

Note: APTC (Advance Premium Tax Credit), CSR (Cost Sharing Reduction)

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This Is Also Despite Increasing Individual Penalties For Those Not Having Insurance And For Low Income Having Subsidies Available

In 2016, penalties will be the higher of:

- 2.5% of yearly income
- $695 per person ($347.50 per child under 18)
- Future years are adjusted for inflation

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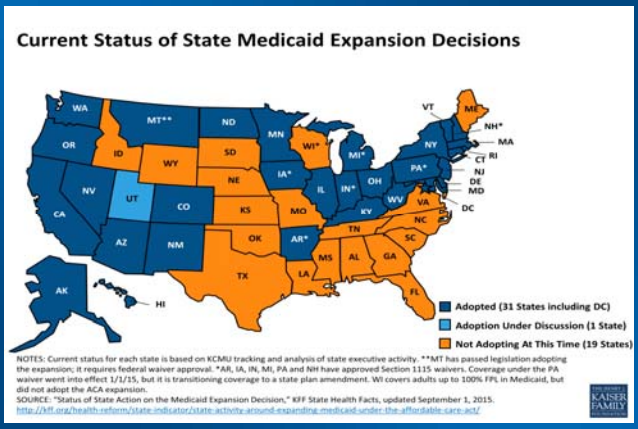
Medicaid Expansion Has Also Plateaued: Delivery System Needs To Anticipate Increasing Charity and Bad Debt Write Offs



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If Fully Expanded, Medicaid Expansion Would Add Only 4.2 M Insureds

Table 2: Number of Uninsured in 2016 (Thousands)

	Number of Uninsured Without Expansion	Number of Uninsured With Expansion	Difference	Percent Difference
Total	14,057	9,789	-4,267	-30%
Alabama	436	259	-177	-41%
Alaska	66	48	-17	-26%
Florida	2,587	1,837	-750	-29%
Georgia	1,249	860	-389	-31%
Idaho	161	103	-59	-36%
Kansas	233	156	-77	-33%
Louisiana	488	295	-193	-40%
Maine	92	52	-40	-44%
Mississippi	332	192	-139	-42%
Missouri	485	294	-191	-39%
Nebraska	128	87	-42	-33%
North Carolina	1,021	709	-313	-31%
Oklahoma	422	295	-127	-30%
South Carolina	490	330	-160	-33%
South Dakota	58	33	-25	-43%
Tennessee	562	383	-179	-32%
Texas	4,076	2,969	-1,107	-27%
Utah	263	195	-68	-26%
Virginia	628	448	-179	-29%
Wisconsin	233	212	-21	-9%
Wyoming	46	32	-14	-30%

Source: Urban Institute Analysis based on HIPSM-ACS, 2015.

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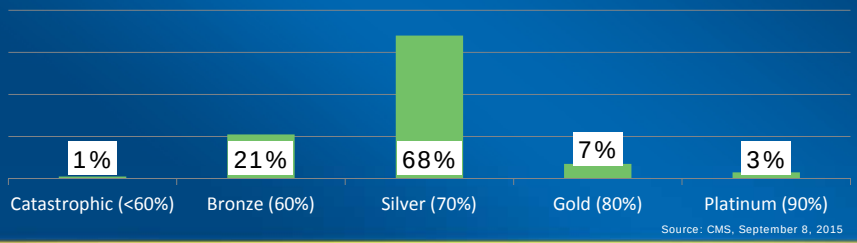
90% of Exchange Products (Metals) Being Selected Have Large Deductibles and Copayments (<70% Coverage Of Average Expense)

June 30, 2015 Effectuated Enrollment by Metal
(Metal is Expected Coverage of Average Person's Cost of Care or Actuarial Value)
Total Enrollment of 9,949,079



Source: CMS, September 8, 2015

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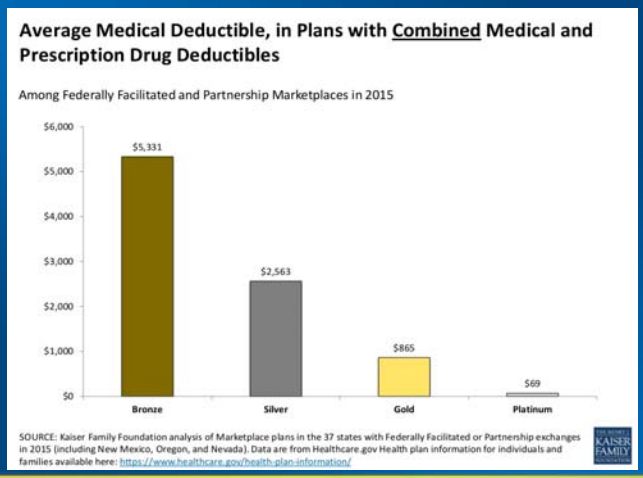
Bronze Deductible Is $5,331 And Silver is $2,563



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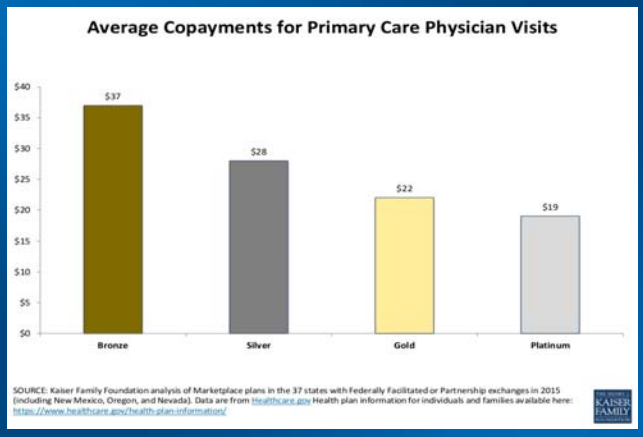
Bronze PCP Copayment Is $37 and Silver Is $28



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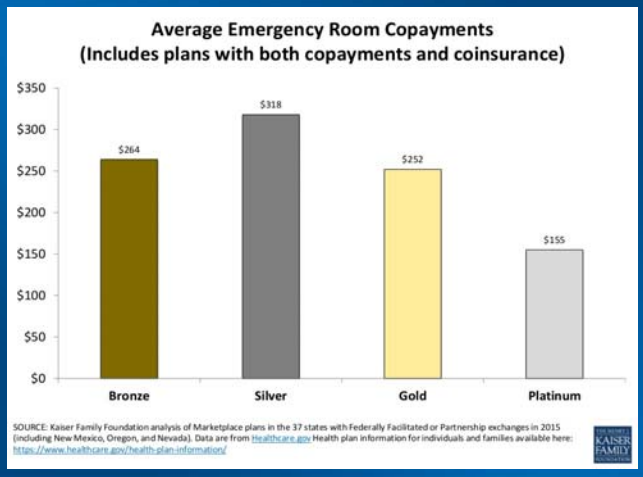
Bronze ER Copayment Is $264 and Silver Is $318



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There are Cost Sharing Reductions Available to Low to Moderate Marketplace Enrollees But There is Still Substantial Cost Sharing

Increases for Silver Plan (70% Coverage)

Income Level as Percent of FPL*	Percent of Average Person's Cost of Care or Actuarial Value
100-150($24250-36375)	94%
150-200($36375-48500)	87%
200-250($48500-60625)	73%

*Federal Poverty Level For Family of Four in 2016

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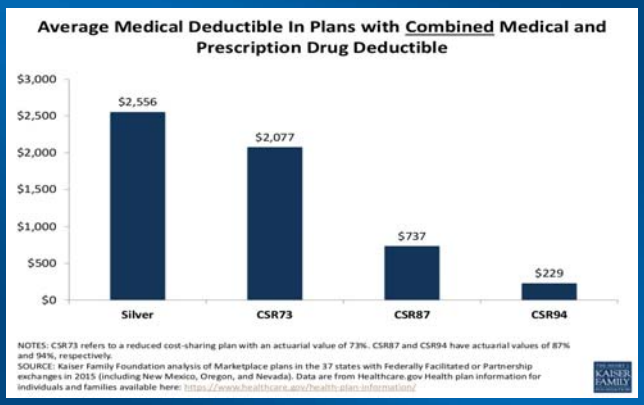
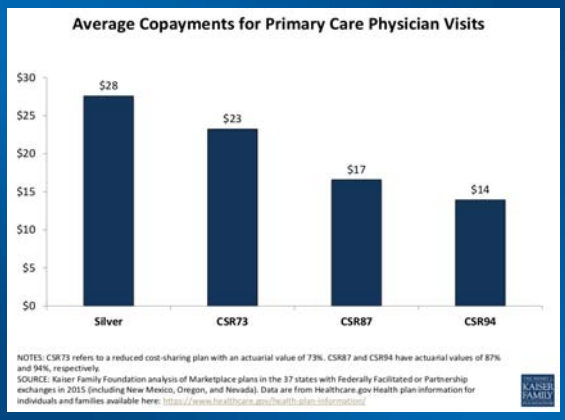
Deductibles Are Still Large Even With Reduced Cost Sharing



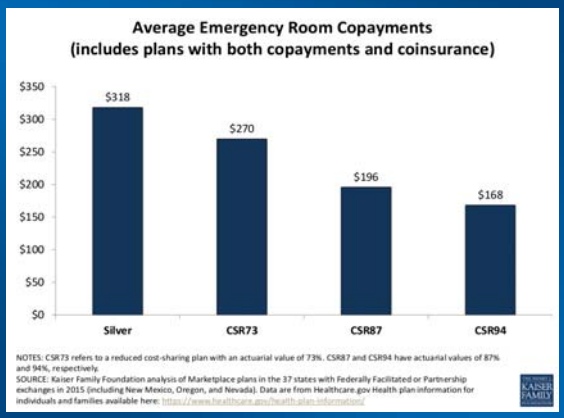
CSR73, CSR87 and CSR94 refer to subsidy tiers – see prior slide

PCP Copays Are Still Large Even With Reduced Cost Sharing



CSR73, CSR87 and CSR94 refer to subsidy tiers – see prior slide

ER Copays Are Still Large Even With Reduced Cost Sharing



CSR73, CSR87 and CSR94 refer to subsidy tiers – see prior slide

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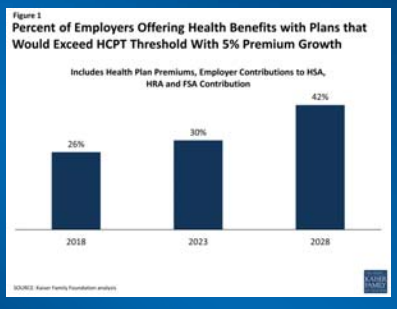
HCPT-High Cost Plan Tax or Cadillac Tax Will Be An Accelerant Soon Affecting 26% of Employers In 2018



- In 2018, Cadillac tax imposes a 40% excise tax on plans that exceed $10,200 individual and $27,500 two adults/family.
- Remedial actions will include increasing deductibles and other cost sharing, eliminating covered services, capping or eliminating FSA, HSA or HRA accounts, or limiting or incentivizing choice of preferred providers.

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So What Does This Mean For Delivery and For Access to Care?

- How will consumers make decisions?
- Will share shift from traditional sites?
- Are there implications for financial operations?

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For Price Shoppers, Consumers Will Buy Care Based On Service And Out of Pocket Expense

- Consumers maximize value; that is, benefits offered are compared to price (measured in expense and opportunity cost)
- For routine health care services:
  - Benefit differentiation is generally related to brand, credentialing, availability (e.g., wait time) and perceived patient service levels. There is little information available about actual quality differences.
  - Expected out of pocket expense is related to estimated expense less coverage for services to be provided. However, for price shoppers there is little or no coverage because deductibles will not be met. Price will be their out of pocket expense.

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For Quality Shoppers, Consumers Will Again Buy Care Based On Service And Out Pocket Expense

- Again, consumers maximize value; that is, benefits offered are compared to price (measured in out of pocket expense and opportunity cost)
- For intensive (tertiary and quaternary care) services
  - Benefit differentiation is again related to brand and credentialing. Availability and perceived service levels are less important due to the often life-saving or maintenance of high quality of life intervention being sought. Importantly, there is emerging information about quality of tertiary and quaternary services to aid in consumer and referring physician decision making. *(However, presentation of this emerging quality information is not included in this presentation – DHK)*
  - Because of the high cost of the interventions, deductibles are quickly met and coverage is full service (unless restricted through PPO or HMO coverage). Price becomes an immaterial consideration.

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So What Are The Market Opportunities / Implications For The Price / Service Shopper Segment

- Growth of Non-Traditional Delivery Sites/Programs That Will Be Selected Mostly Based on Price
  - Urgent Care
  - Retail
  - Telemedicine
  - Concierge
- Improved Consumer Information/Transparent Pricing
- Increased Attention to Revenue Cycle Management

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"When I grow up, I want to go into medicine and help people who can pay out of pocket."

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What Is Urgent Care?

Conditions that require immediate but not emergency room care:

- Fever, sore throats, coughs, earaches
- Eye and bladder infections
- Sprains
- Minor cuts and lacerations
- Sports physicals
- Minor burns
- Occupational health

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What Is Urgent Care?

Urgent care centers are increasingly become referral source for hospitals and physicians:

- Primary care
- Orthopedic surgery
- ENT
- Hospitals

- A 2009 RAND Corp. study reported 14 to 27% of ED visits could be handled by urgent care centers or retail clinics.

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Where Does Urgent Care Fit Into The Continuum?

Continuum of Care

	Lower Acuity			Higher Acuity
	Retail Clinic	Primary Care	Urgent Care	Emergency Rooms
Convenience	High	Low	High	Low
Delivery of Care	Low	High	High	High
Pricing	$80	$130	$130	$650
Challenges	• Physicians not on-site • Do not diagnose / treat mid-acuity patients	• Shortage of PCPs • Appointments impair the ability to deliver timely care • Lack of mid-acuity care (X-rays, stitches, etc.)	• Patient awareness of the urgent care model • Limited range of services	• Overcrowding • Long wait-times for non-emergency patients • Expensive for patients and providers

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From A Service Perspective, Urgent Care Centers Outperform PCP Offices, Retail Clinics And Emergency Departments

- Only 29% of primary care physicians have after-hours coverage
- Wait time is typically less than 30 minutes in an urgent care center compared to multi-hours in an emergency department
- Patients are seen by an MD versus a nurse practitioner in a retail clinic
- Imaging and other services (laboratory) are often available

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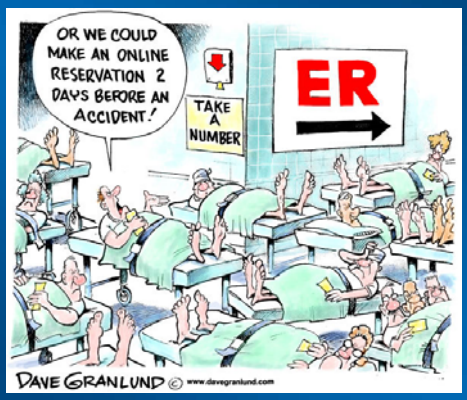

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Urgent Care Center Pricing Versus Emergency Departments

Cost Estimates for Emergency Rooms vs. Urgent Care Centers

The following estimated costs were prepared by Medica Choice Network for nine of the most common reasons people visit the ER. They were determined by calculating the average number on claims submitted in 2010 to the Medica Choice Network, a system of more than 4,000 medical offices, clinics and hospitals across four Midwestern states

Condition	Emergency Room Cost	Urgent Care Cost
Allergies	$345	$97
Acute Bronchitis	$595	$127
Earache	$400	$110
Sore Throat	$525	$94
Pink Eye	$370	$102
Sinusitis	$617	$112
Strep Throat	$531	$111
Upper Respiratory Infection	$486	$111
Urinary Tract Infection	$665	$112

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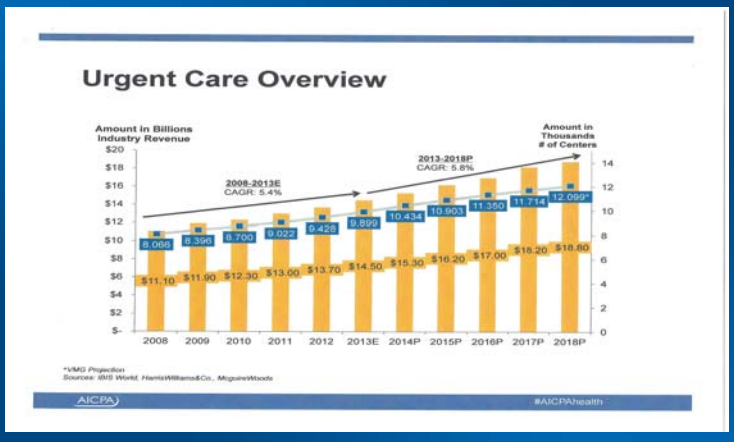
Urgent Care Centers Are Growing at CAGR of 5.8%



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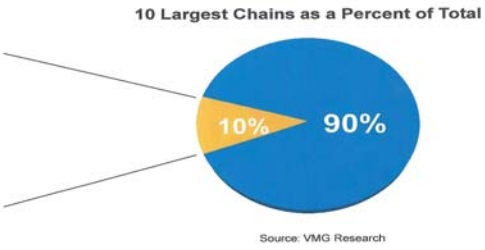
Urgent Care Center Market Remains Fragmented

Current Trends – Urgent Care Market

LARGEST URGENT CARE CHAINS AS OF JUNE 2014

	#of clinics
Concentra	330
US HealthWorks	145
MedExpress	137
Nextcare	108
FastMed	76
AFC Doctors Express	71
CareSpot	64
Patient First	52
Doctors Care	52
Aurora Health Care	39
Total	1074



Fragmented Industry

What are Retail Clinics?

- Retail clinics are ambulatory care sites typically located in and associated with brand-name retailers, including pharmacies, groceries and big-box stores
- These clinics provide low level acute services – routine illness, vaccinations, basic screenings which is in contrast to urgent care centers that provide higher acuity care
- Common conditions include: pharyngitis, otitis media, acute sinusitis, conjuctivitis and urinary tract infections
- They offer walk-in availability, short or no wait times and extended weekday and weekend hours of operation
- Prices are typically fixed and transparent and generally posted on-sire and on-line
- They are typically staffed by NPs and Pas with some physician oversight

Source: Robert Wood Johnson Foundation, The Value Proposition of Retail Clinics, April, 2015

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What Is The Cost Of Care To A Patient At A Retail Clinic Versus Other Sites?

- The average cost of care for treatment of otitis media, pharyngitis and urinary tract infection across alternative sites of care:
  - Retail Clinic - $110
  - Urgent Care Center - $156
  - Physician Office - $166
  - Emergency Department - $570

    Source: The Cost an Quality of Care for Three Common Illnesses at Retail Clinics Compared to Other Medical Settings, Annals in Internal Medicine, September 1, 2009
  - Other studies provide similar findings

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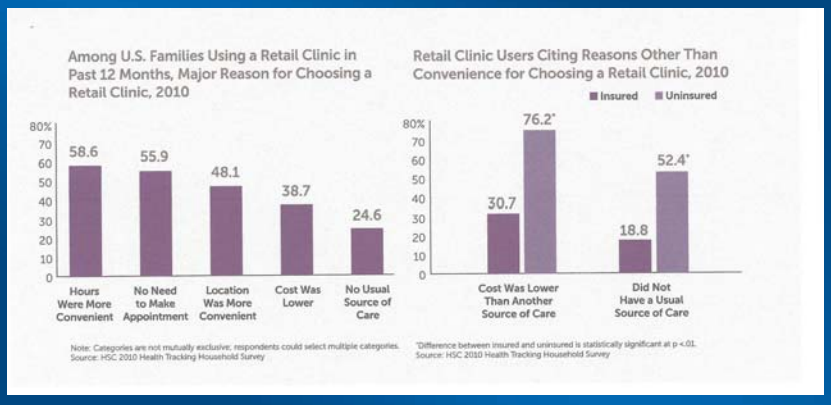
Why Do Patients Use A Retail Clinic?



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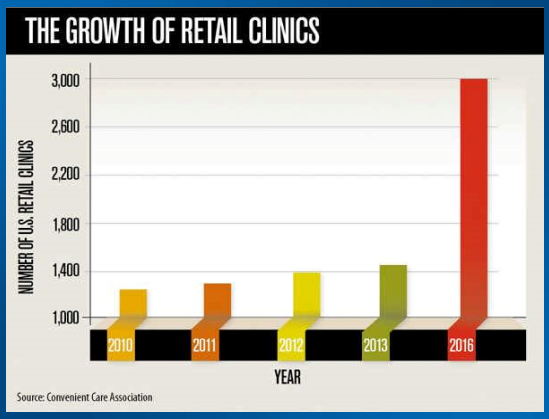
What Is The Retail Clinic Industry Growth Rate?



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What Is The Ownership Structure Of Retail Clinics?

Retail Clinic	Number of sites	Market Share	Health System Affiliations[41]
CVS MinuteClinic	901	50%	47
Walgreens Healthcare Clinic	437	24%	6
Kroger Little Clinic	140	8%	4
Walmart Retail Clinics	103	6%	46
Target Clinic	80	4%	2
RiteAid RediClinic	30	2%	3

Health system affiliations include: Geisinger and Weis, Emory and CVS Minute Clinic, Heritage Provider Network and Rite Aid, Advocate and Walgreens, Scott & White and Walgreens, Sutter and Rite-Aid, UCLA and CVS Minute Clinic

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What is the Retail Clinic Business Model?

- Retail Clinics are low-margin businesses
- They cost $50,000 to $250,000 to build out
- They are 150 to 250 square feet in size
- Revenues are upwards of $500,000 per year
- They typically see 10 to 30 patients per day
- They are staffed by NPs and PAs

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What Is Telemedicine Clinical Model?

- Telemedicine or telehealth refers to having virtual visits, either by phone or online video connection, with physicians, nurse practitioners and physician assistants
- Generally, doctors need to be licensed in the state where the patient is located
- Care is usually live video (synchronous) but could be store-and-forward (asynchronous including secure email), remote patient monitoring and mobile health (mHealth)
- Before the visit, patients register providing background and medical information

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What Is Telemedicine Clinical Model? (Con't)

- Typical diagnoses

- Research shows that about 85% of the visits can be treated just through the
- video visit. Of those, about 17% of the patients are referred for in-person visits

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What Is Telemedicine Clinical Model? (Con't)

- Emerging as a delivery model is having patients receive live telehealth consults with a physician from a retail clinic "originating site of care". This is proving particularly useful when cases are not routine
- Telehealth providers typically emails prescriptions to pharmacy
- Provides higher level of support from nurse call centers

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What Is Telemedicine Clinical Model? (Con't)

- Care is usually available 24/7
- American Well and Teladoc connect to patients to doctors directly as opposed to going through a call center
- Epic and other medical record system need to be modified to allow integration of telemedicine visit records; telemedicine providers have unique record keeping systems

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What is Telemedicine Patient Experience?

- Patients seem to like telemedicine experience

NowClinic by the numbers

- 96% of users chose online, 4% chose phone
- 95% would "definitely use again"
- 85%+ saved a trip to ER, UC, PCP or convenience care clinic
- 93% saved money
- 88% saved personal time
- 87% saved time away from work
- 15% are repeat users
- 64% of patients are female
- 53% of patients are 19–30 years old
- Average age: 38

re demands in the 21st century

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What is Telemedicine Business Model?

- Leading vendors include: Teladoc, American Well, Doctor on Demand, Carena, Healthspot and MDLive. Carena is an ingredient (as opposed to a consumer) brand.
- American Telemedicine Association forecasts 450,000 primary care visits in 2015. Primary care visits are identified as their fastest growth area in telemedicine
- IMS Research (IHS) forecasts that telecommunications-based health services will grow by 300+% by 2017

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What is Telemedicine Business Model? (Con't)

- United Healthcare, Anthem, CVS Caremark and Walgreen's as well as selected regional health plans are promoting telemedicine (virtual visits) as a lower cost substitute for retail clinic, urgent care center and emergency department visits
- Revenue models vary
  - Teladoc charges a membership fee
  - Doctor on Demand and American Well charge per visit ($40-49)
- 74% of patients are open to the concept of "virtual" or technology facilitated visit
- Patients age 40 and under are 50% more likely to not have a primary care physician than older patients

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Concierge Or Retainer Based Care – A Special Situation

- Within price shoppers, there is a sub-segment that is willing to pay more for care for a higher level of service
- Likewise, the current primary care physician shortage — driven by an increase in the number of people who have health insurance, aging, and growth of the U.S. population – continues and is estimated to reach 33,000 primary care physicians by 2035, with an especially steep trajectory over the next 10 years (American Academy of Family Physicians, 2015)
- This imbalance of supply and demand has led to the growth of concierge physicians. In early 2013, it was estimated that there were between 5,000 and 5,500 concierge and DPC physicians in the United States (CMT, 2014a). In 2014, it has been estimated that the number of these physicians have grown to as much as 12,000+ in the United States.

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What Is Concierge Medicine Or Direct Primary Care?

- Concierge medicine practices typically charge a monthly or annual fee so that the patient receives additional access and personalized care
- Range of access and amenities varies but could include: 24-hour physician availability through cell phone, text and email; telephone consultations; extended time appointments (30-60 minutes); executive-type physicals; expedited/same day appointments; in-hospital/home visits; follow-up calls after specialist referral; and lifestyle/prevention care plans
- There are two types of plans
  - Hybrid which charge the concierge medicine registration fee but accept insurance
  - Direct which do not accept insurance and therefore reduce their overhead

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What Do Concierge Medicine Physicians Charge?

- Approximately two-thirds of concierge physicians charge less than $135 per month (Association of Mature American Citizens, 2014)
- Generally, the more charged per month, the smaller is the physician's patient's panel
  - A typical PCP sees 20-24 patients per day
  - A concierge physician charging $600 per year will see 6-8 patients per day
- The average salary for a concierge physician is $150,000-$300,000
- There may legal issues related to health plan hold harmless provisions requiring participating providers to not charge patients for services covered by the plan other than co-pays, coinsurance and deductibles

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A New Concierge Medicine Model With Broad Market Appeal

- Emerging as an alternative concierge medicine model is One Medical Group, which started in San Francisco in 2007 and now has offices in New York City, Boston, Chicago, Los Angeles, Phoenix and Washington, DC.
- Practices are technology enabled allowing for better staffing ratios (1.5 support staff per doctor versus average of 3.5)
- Technology is proprietary; Epic is not used
- Providers have 35% fewer patients that typical primary care physicians so appointments are longer
- Same and next day appointments are available
- 95% of appointments start on-time or early

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A New Concierge Medicine Model

- Appointments and prescription renewals may be booked via phone, app or online
- Physicians encourage direct email with patients
- Common medical issues are treated through use of a mobile app
- Personalized, ongoing care plans employing holistic and integrative care are used
- Physicians are board certified from the best schools
- Physicians coordinate care with specialists
- In NYC, insurance plans accepted include: Aetna, Cigna, Empire BCBS, EmblemHealth, Multiplan, Oscar, Oxford, The Empire Plan and United Healthcare

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A New Concierge Medicine Model (Con't)

- One Medical Group charges a membership fee of $149 to $199 per year, depending on location, to support technology enabled infrastructure
- This membership fee, per the website, is not a requirement of joining; though most pay it
- The website notes that "those who cannot afford or choose not to pay the fee for reasons of their own choosing are also welcome"; there is no discrimination among patients based on whether the fee is paid or not.
- Consumers provide consistently high ratings for the group across its sites
- Money back satisfaction guarantee is provided

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A New Concierge Medicine Model (Con't)

- One Medical Group physicians are salaried
- An associated practice management company, 1Life Healthcare, Inc. is used to provide support and to avoid corporate practice of medicine violations
- Funding is provided by Maverick Capital, Benchmark, Oak Investment Partners and DAG Ventures
- Founder, Thomas Lee, is a serial entrepreneur having successfully developed Epocrates, the interactive medical and drug reference guide for physicians
- Technology enabled primary care practice may be a disruptive innovation

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What Information Will Be Available To Price Shoppers To Aid In Decision Making?

- As deductibles grow in size and prevalence, there will be increased demand for transparency, that is, information about provider price as well as service and quality
- This has led to the use of navigators and the creation of consumer information data bases
- Industry leaders include Castlight Health and Healthsparq
- For very routine services like the cost of an imaging study, information provided tends to accurate and useful
- When more complex services are investigated, the information tends to be weaker because of the absence of episodic pricing

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What Information Will Be Available To Price Shoppers To Aid In Decision Making?

- The absence of episodic pricing is in part due to providers billing on a fee for service as opposed to a fee for episode or bundled basis
- Advocacy groups include: American Board of Internal Medicine Foundation (Choosing Wisely); California Healthcare Foundation; Catalyst for Payment Reform; Clear Health Costs; Change Healthcare; Costs of Care; Council for Affordable Health Insurance; Emergency Care Research Institute; FAIR Health; Healthcare Bluebook; Healthcare Cost Institute; Health Care Incentives Institute; and HFMA – Price Transparency Task Force

What Information Will Be Available To Price Shoppers To Aid In Decision Making?

Many state governments have taken action to aid consumers

Selected State-Level Price-Transparency Initiatives*

State	Type of Provider	Information Reported	Source
California	Hospitals	Median charge by hospital for common surgeries, including digestive, female system, heart and circulatory, male system, obstetrical, skeletal, thyroid, urinary procedures. Quality data by hospital are also available elsewhere on Web site.	www.oshpd.ca.gov/commonsurgery
Massachusetts	Hospitals, medical groups	Both summary and detailed average costs that commercial health plans pay, by provider, for common cardiac, imaging, obstetrics, orthopedic, pulmonary, and select other procedures. Listed alongside provider-level quality information, if available.	http://hcqcc.hcf.state.ma.us
Minnesota	Clinics, medical groups, hospitals	Average payment made by insurance plans for select gastrointestinal procedures, laboratory services, mental health services, obstetrical services, office visits, surgical procedures. Quality ratings by site of care are also available at same Web page.	www.mnhealthscores.org
New Jersey	Hospitals	Average hospital charges and length of stay for most common major diagnostic categories and diagnosis-related groups.	www.njhospitalpricecompare.com
New Hampshire	Hospitals, surgery centers, physicians, other health care professionals	Expected out-of-pocket and total price of preventive health services, emergency visits, radiology procedures, surgical procedures, and maternity services by insurance plans (includes prices for uninsured).	www.nhhealthcost.org

* "Charges" (California and New Jersey) reflect the prices that hospitals first charge for a procedure and are much higher than the actual rates paid by public and private payers. Information is from the National Conference of State Legislatures and the individual Web sites listed in the table.

What Information Will Be Available To Price Shoppers To Aid In Decision Making?

States have passed or are soon expected to pass All-Payer Claims Database laws requiring health plans to share claims, eligibility and provider files to be combined with Medicare and Medicaid data to create a robust source of information that can be mined to provide meaningful consumer information

Information Typically Collected in an APCD	Data Elements Typically Not Included in an APCD
• Encrypted SSN or member identification number • Type of product (HMO, POS, indemnity, etc.) • Type of contract (single person, family, etc.) • Patient demographics (DOB, gender, ZIP code) • Diagnosis, procedure, and NDC codes • Information on service provider • Prescribing physician • Health plan payments • Member payment responsibility • Type and date of bill paid • Facility type • Revenue codes • Service dates	• Services provided to uninsured • Denied claims • Workers' compensation claims • Premium information • Capitation fees • Administrative fees • Back end settlement amounts • Referrals • Test results from lab work, imaging, etc. • Provider affiliation with group practice • Provider networks

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What Information Will Be Available To Price Shoppers To Aid In Decision Making?

- Health Plans having identified provision of consumer information as a differentiator are being to innovate
- The national BlueCross Blue Shield Association is creating Axis which will launch in January, 2016 and will include 36 million claims representing $350 billion in spend and drawn from all BCBS Plans
- Recently, Anthem and Castlight Health announced an initiative to provide similar consumer price and quality information

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What Is The Impact Of Increased Deductibles On Provider Revenue?

- The increase in deductibles will affect provider revenue and require changes in billing, credit and collection operations
- Hospital self-pay (balance after insurance payments) average 7.3% of total patient revenue. (Moody's, 2012, Audit of 203 hospitals)
- Physician self-pay average 23.2% of total patient revenue. (MGMA, 2010)
- 97% of hospitals report growth in self-pay with one-third indicating growth of over 10%
- A large proportion of self-pay ends up as bad debt with 2013 recovery rates for hospitals being 15.3% and for non-hospital providers being 21.8% (ACA International's Top Collection Markets Survey)

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What Is The Impact Of Increased Deductibles On Provider Revenue?

- University of Rochester (hospital) only experience

	2009	2014
Bad Debt as a Percent of Total Patient Revenue	2.92%	4.23%

- Proposed HFMA and ACA International Standards will limit collection processes
  - Allowing patients 120 days to pay a medical bill before reporting delinquency to a credit bureau
  - Removing paid medical debt from credit reports within 45 days
  - Reporting all transactions (payments, partial payments, no payments) to credit bureau

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What Is The Impact Of Increased Deductibles On Provider Revenue?

- Best practices include:
  - Establishing patient responsibility ideally on a pre-service basis; if not possible, on an accelerated basis after care delivery
    - Insurance eligibility verification
    - Likely clinical workflow including diagnosis and procedure codes to be used for billing
    - Estimate of insurance coverage
    - Estimate of patient liability

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What Is The Impact Of Increased Deductibles On Provider Revenue?

- Establishing pre-service collection processes that financial screening/counseling, use of propensity to pay analytics, scripting for patient communication and offer an inventory of payment arrangements (credit, debit, ACH/automatic billing)
  - Median point of service per hospital has increased from $700,000 in 2010 to $1.8 million in 2014
  - Median point of service revenue per bed has increased from $2,660 in 2010 to $5,780 in 2013.

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What Is The Impact Of Increased Deductibles On Provider Revenue?

- Adopt simplified, personalized billing using multiple channels for collection
  - Billing statement clarity/use of single integrated statement
  - Use of online billing and payment
  - Use of credit cards, automated and mobile payments
  - Use of inbound/outbound IVR and SMS text messaging

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UR MEDICINE

MEDICINE of THE HIGHEST ORDER

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