A NEW PRIMARY CARE CONTINUUM

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Professor, Public Health Sciences
Executive Professor, Healthcare Management
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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
Average Deductible (Among All Workers) Is $1,077!

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

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.
Two Market Segments Will Emerge

PRICE SHOPPERS
Healthy and not so sick patients who select basic coverage and whose deductibles are frequently not met are more price sensitive

QUALITY SHOPPERS
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

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

Price Shoppers Account For 90% Of The Population And 35% Of The Spend
10% Of The Population Are Quality Shoppers (High Spenders) And 72% Are Consistently In That Segment

Some High Spending Is Persistent, Some Is Episodic

![Diagram showing spending patterns]

- Episodic High Spending: Lower Spending After Period of High Spending (28%)
- Persistent High Spending Over Two Years (42%)
- Some Reduction in Spending in Second Year (30%)
- 2011 High Spenders (in Top 10%)
  - Stayed in Top 10%
  - Fell to 76-90 Percentile
  - Fell to Bottom 75%

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.
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.

<table>
<thead>
<tr>
<th>Date</th>
<th>For/Favor</th>
<th>Against/Oppose</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/22 - 10/4</td>
<td>42.0</td>
<td>49.8</td>
</tr>
</tbody>
</table>

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.

This Is Also Despite 78% Saying That The ACA Has Hurt Or Not Impacted Them or Their Family
Percentage Of Population Insured Has Increased But Seems To Be Leveling Off

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

<table>
<thead>
<tr>
<th>Month</th>
<th>HHS Expected Enrollment</th>
<th>CBO Expected Enrollment (March 2015 Forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>December, 2014</td>
<td>6.3 M</td>
<td></td>
</tr>
<tr>
<td>February, 2015</td>
<td>11.7 M</td>
<td></td>
</tr>
<tr>
<td>March, 2015</td>
<td>10.2 M</td>
<td></td>
</tr>
<tr>
<td>June, 2015</td>
<td>9.9 M</td>
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</tr>
<tr>
<td>December, 2015</td>
<td>9.1 M</td>
<td>11 M</td>
</tr>
<tr>
<td>December, 2016</td>
<td>10 M</td>
<td>21 M</td>
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</table>


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)

Note: APTC (Advance Premium Tax Credit), CSR (Cost Sharing Reduction)
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
If Fully Expanded, Medicaid Expansion Would Add Only 4.2 M Insureds

<table>
<thead>
<tr>
<th>State</th>
<th>Number Without Expansion</th>
<th>Number With Expansion</th>
<th>Difference</th>
<th>Percent Difference</th>
</tr>
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<tbody>
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<td>Total</td>
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<td>Alabama</td>
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<td>Alaska</td>
<td>66</td>
<td>46</td>
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<tr>
<td>Arizona</td>
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<tr>
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<tr>
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<td>150</td>
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<tr>
<td>Colorado</td>
<td>218</td>
<td>196</td>
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<tr>
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<td>488</td>
<td>295</td>
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<tr>
<td>Delaware</td>
<td>90</td>
<td>52</td>
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<tr>
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<td>390</td>
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<tr>
<td>Iowa</td>
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<tr>
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<td>150</td>
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<td>Tennessee</td>
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<tr>
<td>Texas</td>
<td>4,670</td>
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<td>West Virginia</td>
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<td>Wisconsin</td>
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<tr>
<td>Wyoming</td>
<td>422</td>
<td>295</td>
<td>-127</td>
<td>-30.1%</td>
</tr>
</tbody>
</table>

Source: CMS, September 8, 2015

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

- 1% Catastrophic (<60%)
- 21% Bronze (60%)
- 68% Silver (70%)
- 7% Gold (80%)
- 3% Platinum (90%)

Source: CMS, September 8, 2015
Bronze Deductible Is $5,331 And Silver is $2,563

Average Medical Deductible, in Plans with Combined Medical and Prescription Drug Deductibles

Among Federally Facilitated and Partnership Marketplaces in 2015

Bronze PCP Copayment Is $37 and Silver Is $28

Average Copayments for Primary Care Physician Visits

SOURCE: Kaiser Family Foundation analyses of Marketplace plans in all 13 states with Federally Facilitated or Partnership exchanges in 2015, including Texas, Georgia, and Arizona. Date and plan information from HealthCare.gov. Health plan information for Individual and families available here: https://www.kff.org/health-reform/individual-and-family-plan-information/
Bronze ER Copayment Is $264 and Silver Is $318

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 )

<table>
<thead>
<tr>
<th>Income Level as Percent of FPL*</th>
<th>Percent of Average Person’s Cost of Care or Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-150($24250-36375)</td>
<td>94%</td>
</tr>
<tr>
<td>150-200($36375-48500)</td>
<td>87%</td>
</tr>
<tr>
<td>200-250($48500-60625)</td>
<td>73%</td>
</tr>
</tbody>
</table>

*Federal Poverty Level For Family of Four in 2016
Deductibles Are Still Large Even With Reduced Cost Sharing

Average Medical Deductible in Plans with Combined Medical and Prescription Drug Deductible

- Silver: $2,596
- CSR73: $2,077
- CSR87: $732
- CSR94: $20

NORES: CSR73 refers to a reduced cost-sharing plan with an actuarial value of 73%. CSR87 and CSR94 have actuarial values of 87% and 94%, respectively.

PCP Copays Are Still Large Even With Reduced Cost Sharing

Average Copayments for Primary Care Physician Visits

- Silver: $28
- CSR73: $29
- CSR87: $17
- CSR94: $14

NORES: CSR73 refers to a reduced cost-sharing plan with an actuarial value of 73%. CSR87 and CSR94 have actuarial values of 87% and 94%, respectively.
ER Copays Are Still Large Even With Reduced Cost Sharing

Average Emergency Room Copayments (includes plans with both copayments and coinsurance)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver</td>
<td>$318</td>
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<tr>
<td>CSR73</td>
<td>$270</td>
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<tr>
<td>CSR87</td>
<td>$246</td>
</tr>
<tr>
<td>CSR94</td>
<td>$168</td>
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</table>

NOTE: CSR73 refers to a reduced cost-sharing plan with an actuarial value of 73%. CSR77 and CSR94 have actuarial values of 77% and 94%, respectively.

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.
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?

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.
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.

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
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
What Is Urgent Care?

Urgent care centers are increasingly becoming a 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.

Where Does Urgent Care Fit Into The Continuum?

![Continuum of Care Table]

<table>
<thead>
<tr>
<th>Lower Acuity</th>
<th>Higher Acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail Clinic</td>
</tr>
<tr>
<td>Convenience</td>
<td>High</td>
</tr>
<tr>
<td>Billing</td>
<td>$80</td>
</tr>
<tr>
<td>Challenges</td>
<td>- Providers not available</td>
</tr>
<tr>
<td></td>
<td>- Do not diagnose treat and release patients</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

35

36
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
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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Emergency Room Cost</th>
<th>Urgent Care Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>$345</td>
<td>$97</td>
</tr>
<tr>
<td>Acute Bronchitis</td>
<td>$595</td>
<td>$127</td>
</tr>
<tr>
<td>Earache</td>
<td>$400</td>
<td>$110</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>$525</td>
<td>$94</td>
</tr>
<tr>
<td>Pink Eye</td>
<td>$370</td>
<td>$102</td>
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<tr>
<td>Sinusitis</td>
<td>$617</td>
<td>$112</td>
</tr>
<tr>
<td>Strep Throat</td>
<td>$531</td>
<td>$111</td>
</tr>
<tr>
<td>Upper Respiratory Infection</td>
<td>$486</td>
<td>$111</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>$665</td>
<td>$112</td>
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</table>
Urgent Care Center Market Remains Fragmented

Current Trends – Urgent Care Market

<table>
<thead>
<tr>
<th>LARGEST URGENT CARE CHAINS AS OF JUNE 2014</th>
<th># of clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentra</td>
<td>330</td>
</tr>
<tr>
<td>US HealthWorks</td>
<td>145</td>
</tr>
<tr>
<td>MedExpress</td>
<td>137</td>
</tr>
<tr>
<td>NextMed</td>
<td>108</td>
</tr>
<tr>
<td>FastMed</td>
<td>76</td>
</tr>
<tr>
<td>AFC Doctors Express</td>
<td>71</td>
</tr>
<tr>
<td>CareOne</td>
<td>64</td>
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<tr>
<td>Patient First</td>
<td>52</td>
</tr>
<tr>
<td>Doctors Care</td>
<td>52</td>
</tr>
<tr>
<td>Aurora HealthCare</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>1,974</td>
</tr>
</tbody>
</table>

10 Largest Chains as a Percent of Total

90%
10%

Source: WMI Research

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, conjunctivitis 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-site 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
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

Why Do Patients Use A Retail Clinic?

[Data regarding reasons for using retail clinics, as shown in diagrams]
What Is The Retail Clinic Industry Growth Rate?

The Growth of Retail Clinics

What Is The Ownership Structure Of Retail Clinics?

<table>
<thead>
<tr>
<th>Retail Clinic</th>
<th>Number of sites</th>
<th>Market Share</th>
<th>Health System Affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS MinuteClinic</td>
<td>901</td>
<td>50%</td>
<td>47</td>
</tr>
<tr>
<td>Walgreens Healthcare Clinic</td>
<td>437</td>
<td>24%</td>
<td>6</td>
</tr>
<tr>
<td>Kroger Little Clinic</td>
<td>140</td>
<td>6%</td>
<td>4</td>
</tr>
<tr>
<td>Walmart Retail Clinics</td>
<td>103</td>
<td>6%</td>
<td>46</td>
</tr>
<tr>
<td>Target Clinic</td>
<td>80</td>
<td>4%</td>
<td>2</td>
</tr>
<tr>
<td>RiteAid RediClinic</td>
<td>30</td>
<td>2%</td>
<td>3</td>
</tr>
</tbody>
</table>

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
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
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.

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.
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

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
What is Telemedicine Patient Experience?

• Patients seem to like telemedicine experience

NewClinic by the numbers
• 96% of users chose online, 4% chose phone
• 95% would “definitely use again”
• 85% saved a trip to ER, UC, FCP 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
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.

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.
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.

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
### 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 be 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

### 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 than typical primary care physicians so appointments are longer
- Same and next day appointments are available
- 95% of appointments start on-time or early
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

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
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

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
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

Many state governments have taken action to aid consumers
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.

<table>
<thead>
<tr>
<th>Information Typically Available From Claims Files</th>
<th>Information Typically Available From Other Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Username, gender, and identification numbers</td>
<td>Policies, procedures of the government</td>
</tr>
<tr>
<td>Type of product (MD, POS, Indemnity, etc.)</td>
<td>Hospitalolinic claims</td>
</tr>
<tr>
<td>Tiers of benefit (single, family, etc.)</td>
<td>Prescriber information</td>
</tr>
<tr>
<td>Patient demographic (DSI, gender, ZIP code)</td>
<td>Provider information</td>
</tr>
<tr>
<td>Claimants, structure, and NICWestern</td>
<td>Physician referrals</td>
</tr>
<tr>
<td>Information on service provider</td>
<td>Total volume of procedures</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Total charges at each provider</td>
</tr>
<tr>
<td>Health status narratives</td>
<td>Total revenue from each provider</td>
</tr>
<tr>
<td>Member treatment responsibility</td>
<td>Total volume of procedures at each provider</td>
</tr>
<tr>
<td>Type and date of treatment</td>
<td>Total charges at each provider</td>
</tr>
<tr>
<td>Facility type</td>
<td>Total revenue from each provider</td>
</tr>
<tr>
<td>Admission status</td>
<td>Total volume of procedures at each provider</td>
</tr>
<tr>
<td>Spectrum claims</td>
<td>Total revenue from each provider</td>
</tr>
</tbody>
</table>

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.
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)

What Is The Impact Of Increased Deductibles On Provider Revenue?

- University of Rochester (hospital) only experience

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<thead>
<tr>
<th></th>
<th>2009</th>
<th>2014</th>
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<tbody>
<tr>
<td>Bad Debt as a Percent of Total Patient Revenue</td>
<td>2.92%</td>
<td>4.23%</td>
</tr>
</tbody>
</table>

- 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
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

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.
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