Patient Advocacy 2.0

A win for you and your members.

You want to lower costs, improve retention, and increase growth. Members are willing to pay for someone they trust to point them to the best, most affordable care.

Patient Advocacy 2.0 can check all these boxes.

point health

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Policy issues that create **personal** problems.

There's no question the U.S. healthcare system needs some serious repairs. The U.S. spends almost 18% of our gross domestic product (GDP) on healthcare, the most in the world. Even worse, around 30% of that spending can be considered wasteful or unnecessary, impacting health plans and their members[1].

We read these and other statistics in the news or on our Twitter feeds all the time. Because of that, it can be easy to forget these policy issues trickle down into people's lives. People like:

Scott Kohan, who underwent **surgery for a broken jaw** at a hospital that was in his carrier's network. But his surgeon wasn't. His share of the bill was **$7,924**[2].

Jessica Pell, who went to a hospital emergency room for **a cut on her ear**. They treated her with a single ice pack and handed her a bill for **$5,751**[2].

Gretchen Liu, who chose to pay the full $40 retail price for a **90-day supply of generic telmisartan** out of her pocket—because the previous time she filled it, her insurance copay was **$285**[3].

Sadly, these true stories aren't rare. Whether covered by a large insurer, not insured at all, or somewhere in between, millions of people are being personally impacted every day by expensive care and a confusing system.

A poor system affects health plans too. When members receive expensive care and get a huge bill in the mail, they're quick to point a finger at their health plan. Angry members are not retained members, which means membership loss for the health plan and most likely bad reviews. Not to mention that replacing those members via new member acquisition is one of the most expensive line items for a health plan's budget.

So while policymakers and big players in healthcare battle over the "best solution," the rest of us in healthcare can make real change right now.

What is **patient advocacy** and how is it evolving?

In general, advocacy is helping patients make decisions or advocate for themselves and their healthcare needs. From locating healthcare resources to negotiating medical bills, advocacy is supporting patients in their healthcare journey.

Since patients' choices can directly impact healthcare costs—and even a "right" choice can still result in quality and cost issues—the concept of equipping plan members with helpful information, tools, assistance, and guidance is a no-brainer for health plans[5].

Patient advocacy offers **real value** to organizations and individuals.

As great as patient advocacy sounds to health plans for containing costs, it doesn't work if members don't participate.

That's why The Karis Group, a Point Health company, conducted a study with Nelson Associates to see if health plan members value patient advocacy services, and if they place a higher value on health plans that offer these services. We'll get to the specific findings later, but to give you a sneak peek: The answer is a definite "yes." And, these perceptions of increased value can be linked to higher Net Promoter Scores (NPS) for health plans. Which means better member satisfaction, retention, and new member growth for your plan.

2

The challenge members and health plans face: **healthcare is hard.**

A bit of a "duh" statement, but why is healthcare hard? There are a lot of valid reasons, but we're going to focus on the complex web of competing solutions facing members today as one of the primary reasons healthcare is hard.

> **High deductible health plans** (HDHPs) are specifically designed to remind members they have "skin in the game." But unless you can compare quality and price ahead of time, how can you be a smarter healthcare consumer?

> Even **"traditional" plan designs** may include confusing provisions like separate ER deductibles, fewer co-pays, more restrictive drug formularies, pre-authorization requirements, network pharmacies, etc.

> **HMO and EPO plans** have always had strict network restrictions, but today it's hard to find health plans of any kind without significant financial penalties for receiving out-of-network care.

> Plus, there are **"wild cards"** like opaque prescription drug pricing, separate Rx deductibles, in-network facilities providing care with out-of-network physicians, embedded and non-embedded family deductibles, and preferred provider tiers.

These efforts to control costs cause members to feel incredibly confused and frustrated. This in turn leads to unwise and unnecessarily expensive care decisions. Those decisions hurt your cost curve and satisfaction ratings, and if members are frustrated enough they'll certainly switch to a different health plan as soon as they can.

Members don't understand or trust healthcare.

At the end of the day, the fact is average Americans don't know enough about healthcare to make informed decisions without expert help. For example:

> Most people don't even know the basics of healthcare. A PolicyGenius survey of 2,000 consumers revealed **96% of Americans couldn't define basic healthcare terms** even though the respondents actually thought they understood them very well[6].

> People often don't make the best choices about where to go for care. The New England Health Institute said **56% of emergency room visits were "totally avoidable."** Several studies suggest many of these cases, such as the 4.3 million chest pain cases ERs saw in 2019, could have been handled in urgent care facilities[7].

> Americans don't trust the information from healthcare industry players. A 2016 Harris Poll revealed **only 16% of U.S. consumers believed health insurers** put patients ahead of profits, and only 9% believed pharmaceutical and biotechnology companies did[8].

When members don't understand or trust healthcare, how can we expect them to make choices that are cost-effective and beneficial to their health?

Members don't know where to start.

In an attempt to fix the issues mentioned above, many health plans have implemented programs to better educate their members and help them manage their care. Unfortunately, most of these initiatives are passive or reactive in nature and require members to know how (and be willing) to actively access them when needed, understand their capabilities and limitations, and know how to use them. As a result:

Members are faced with multiple vendors for different aspects of their care with no clear integration or primary touchpoint for seeking advice or assistance. These programs then go unused or underutilized.

40% of organizations with multiple vendors for benefits said there is a lack of utilization due to a confusing and disjointed experience[9].

Members don't shop around for healthcare discounts. Worse, they don't ask their current providers if discounts are even available for their treatment.

61% of adults surveyed who asked their doctor for a discount got one[10].

Members don't properly review their medical bills. An Equifax audit found that on hospital bills totaling $10,000 or more, the average error was $1,300.

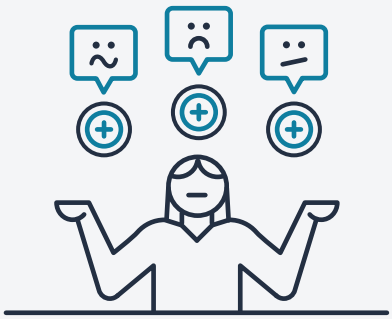
Up to 80% of bills contain errors.

Consequences of disengagement: expensive and ineffective care.

Members aren't engaged with their healthcare, don't know what to look for, and don't have a trusted source of advice and assistance. It's no wonder their care choices and actions (or inaction) lead to poor clinical outcomes and higher medical expenses for themselves and their plans. For example:

Unnecessary medical services waste $210 billion annually.
In a John Hopkins survey of more than 3,000 physicians, respondents said 15 to 30% of medical care delivered is not needed: 22% of prescription medications, 24.9% of medical tests, 11.1% of procedures, and 20.6% of overall medical care[11].

Members typically don't seek second opinions.
Less than 17% of patients seek a second medical opinion after a diagnosis (50% in cases of cancer diagnoses)[12]. Yet the Mayo Clinic reports that as many as 88% of patients who do get a second opinion go home with a new or refined diagnosis, which changes their care plan (and potentially their lives.) Conversely, only 12% receive confirmation that the original diagnosis was complete and correct.



Members often choose the wrong providers.
When members select their own providers and care options, they tend to have low levels of satisfaction with the experience. A 2015 Advisory Board study showed that when people selected a primary care physician on their own, they typically give them a Net Promoter Score (NPS) of +3 on a scale from -100 to +100[13]. (Net Promoter Score, in this context, measures the likelihood of patients to recommend the doctor to a friend, colleague, or family member.) When members used a navigation service to find a provider, they gave the doctor an NPS of +77. And Net Promoter Scores were in the +80s and +90s when they used third-party vendors to find specialists.

3

Smart Healthcare Platform: The next generation of patient advocacy.

We've shown you a lot of the issues in healthcare, but how does patient advocacy fix it? Our solution centers around the belief that health plans and their members receive the most value from an integrated suite of digital + human personalized advocacy services that provide a single touchpoint for information and expert assistance at every step of the healthcare journey.

That's why we created the first-ever Smart Healthcare Platform. Our suite of services combines powerful navigation services, shop-and-compare tools, personalized assistance, and the largest, most flexible selection of cash-pay providers in America on a single, intuitive platform.

Mobile Application.

There's no question health plans need to adopt digital tools to meet their members' expectations and keep them from leaving for another plan that is more tech forward. A 2018 Cognizant report found that health plans offering digital capabilities outperformed others in overall member satisfaction and retention by nearly 5%[14]. Self-service is becoming increasingly popular, so for members who like to have control, our app enables them to view pricing for hundreds of healthcare services. Members can shop and compare doctors, labs, hospitals, medications, and more.

Healthcare Navigation.

Our Smart Healthcare Platform also offers trained patient advocates who listen to members' needs and find their ideal care solution. You get a happy and healthy member who feels cared for without adding any extra work for your team. Plus, our patient advocates provided an average cost savings of 61% over a four-year period as a result of their healthcare navigation recommendations.

Bill Negotiation.

Despite your best efforts, sometimes members don't choose the most affordable care options. This often leads to frustrated members, but with bill negotiation, a member's experience can be completely turned around. Point Health patient advocates work with members and their providers to lower medical bills. This not only helps current members feel cared for, it also helps set your health plan apart. In fact, our survey found that adding a third-party bill negotiation service led to 17.6% average NPS growth.

Done well, patient advocacy services can benefit your health plan in multiple ways:

Cost containment:
Effective advocacy programs result in better utilization as members become smarter healthcare consumers, make fewer poor choices, and are steered toward care that combines quality outcomes and lower costs.

Improved satisfaction and engagement:
Advocacy can improve overall satisfaction and potentially increase attraction and retention. Our research shows that members of health plans who offer third-party advocacy services are more likely to recommend that plan to others.

Lower workloads on your internal team:
When members have access to personalized health advocacy services, they are less likely to call your member services team. This frees up your team to deal with more complex member issues and improve upon your internal services.

4

Research findings on the value of **patient advocacy.**

Patient advocacy services and programs offer a great ROI when you consider that they cut down on your overall cost curve. Patient advocacy increases member retention and savings from not having to constantly acquire new members. Patient advocacy services also cut down medical bills by pointing members to the most affordable care option or lowering a medical bill if they've already gone to an expensive provider.

Despite these benefits, health plans are understandably reluctant to add any expense, no matter how incremental, to their existing costs. But what about members? We know that demand is growing for independent patient advocates hired by individuals[15]. So we wondered if that would translate into a willingness by health plan members to pay extra for these services (either through a premium increase or out-of-pocket)—and how much additional they felt these services were worth.

An original study.

The Karis Group, a Point Health company, partnered with Nelson Associates to conduct a consumer survey of 510 employed adults with health insurance (either group insurance provided by their employer or individually purchased coverage.)

50.68% – Through my employer group

16.56% – Uninsured (no health insurance)

16.23% – Through Medicaid/Medicare/Other Gov.

8.78% – Purchased via ACA (healthcare.gov)

7.74% – Purchased on my own (individual)

The survey was designed to determine how much respondents were willing to pay for patient advocacy services to:

- **Find the best provider** to match their needs and schedule appointments.
- **Search local pharmacies** to identify the best price for their prescriptions.
- **Shop for and suggest** the best and most cost-effective surgery facility for their needs.
- **Handle the transfer** of their medical records.
- **Help negotiate** their medical bills for lower out-of-pocket expenses.

The survey questions included brief descriptions (1–2 sentences) explaining the potential benefits of each of these five advocacy services.

In addition, to help quantify the value to health plans of adding advocacy services, we asked respondents to rate how willing they would be to recommend and promote their health plan if it were to add each of the services (as a way of measuring their Net Promoter Scores[16]).

We also asked respondents to rank the attributes they found most attractive in advocacy services.

Survey results.

Even with minimal explanations about the benefits of each service, **100% of respondents** expressed a willingness to pay at least something additional for all five advocacy services. When asked if they'd be willing to pay extra for at least one of the services, 64.6% said they would. In addition, 25% to 40% of respondents said they'd be willing to pay an average between $1.55 and $2.49 per month extra for each service, or an additional $9.63 per month for the five services.

Key finding.

Of those respondents who indicated which attributes they value most in patient advocacy services, 22% cited objectivity through a neutral advocate company or service, as opposed to through the insurer. (This response was second only to "free of charge" at 29%.)

5 Final thoughts.

Through our work helping clients and their members contain healthcare costs, and through our research on patient advocacy programs, Point Health believes more strongly than ever that effective, objective third-party advocacy programs are an essential part of making healthcare in the U.S. easy to find, easy to understand, and easier to afford.

The need for advocacy services is great and growing, partially thanks to the complexities of today's healthcare system, opaque pricing, and plan designs that put members at even greater financial risk.

Patient advocacy, done well, can have a significant positive impact on health plans through improved cost containment, proactive (rather than reactive) strategies, effective navigation and negotiation services, and improved access to quality, cost-effective care.

Effective, comprehensive advocacy services are not a "do-it-yourself" project. "Advocacy" is premised on trusted third-party individuals. The greatest value to the individual member comes from having complete faith in their advocate's objectivity.

The cost for these services is relatively low, and members are willing to pay more to cover the cost in exchange for having an industry expert on their side who will do the heavy lifting it takes to point them in the right direction.

About **Point Health.**

Point Health is an Austin, Texas-based digital health startup paving the way for major changes in the healthcare industry, primarily through our Smart Healthcare Platform. Our suite of services combines powerful navigation services, shop-and-compare tools, personalized assistance, and the largest, most flexible selection of cash-pay providers in America on a single, intuitive platform. The healthcare system in the U.S. is confusing to navigate, but Point Health is guiding patients towards healthcare that is easier to find, understand, and afford. Visit PointHealth.com to learn more.

6 Appendix.

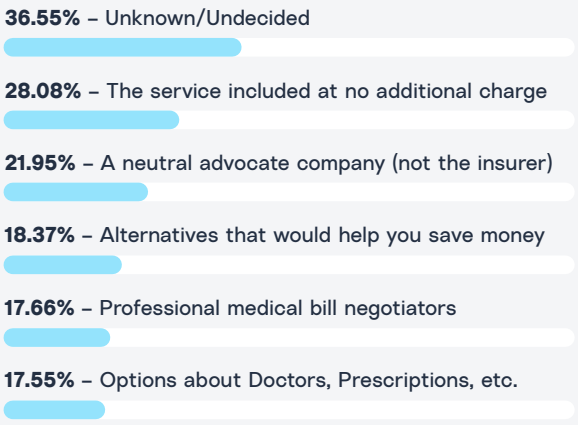
Survey methodology.

Respondents were included only if they had a group or individual healthcare insurance plan. Purchasing decisions and buying behaviors are made by humans with “bounded rationality” and limited information.

Attitudinal research generally yields very weak correlations and predictive power, but very strong predictive power by assessing revealed preferences through actual purchasing decisions and behavior (even if only in a simulated purchase.)

In this survey, we simulated consumer purchasing decision behavior by offering participants a set of alternative features at various prices to determine how many would be willing to pay how much for patient advocacy services.

Most Important Components of a Healthcare Advocacy Service (n=340)



Survey details.

Policyholder Value Study: Respondent Profile

Bill negotiation (n=468)
39.4% of respondents were willing to pay an additional average monthly premium of +$2.49 for an individual plan and +$6.66 for a family plan.

Surgery facility location service (n=452)
31.4% of respondents were willing to pay an additional average monthly premium of +$2.02 for an individual plan and +$5/30 for a family plan.

Prescription shopper service (n=394)
30.7% of respondents were willing to pay an additional average monthly premium of +$1.99 for an individual plan and +$5.33 for a family plan.

Medical record transfer service (n=389)
25.2% of respondents were willing to pay an additional average monthly premium of +$1.55 for an individual plan and +$4.19 for a family plan.

Healthcare provider match/scheduling service (n=381)
24.7% of respondents were willing to pay an additional average monthly premium of +$1.58 for an individual plan and +$4.23 for a family plan.

For all five services (n=381)
100% of respondents were willing to pay an additional average monthly premium of +$0.07 monthly for an individual plan and +$0.23 for a family plan.

The 25% to 40% of respondents showing a willingness to pay for the five patient advocacy services were, on average, willing to pay +$9.63 per month in additional premium for all five services.

7

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