



Independent Review of Everside Health's Client Savings Methodology

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I. EXECUTIVE SUMMARY

Everside Health, Inc. (Everside) engaged Milliman to review two of its methodologies for analyzing client savings related to usage of Everside's Direct Primary Care (DPC) health centers. Everside provided supporting data summaries and methodology descriptions for us to review. This report describes Everside's services (Section II), savings methodologies and data sources (Sections III and IV), discusses some limitations of the savings approaches used by Everside (Section V), and outlines important caveats and limitations of our review (Section VI).

This report is intended to provide feedback on the actuarial appropriateness of Everside's methodologies as they were presented to us and may not be appropriate and should not be used for any other purpose. Actual experience will differ from historical experience and the results for any particular employer client will be unique to the characteristics of that employer and other external factors not considered in this assessment. We are only commenting on the general approaches provided to us by Everside for calculating estimated savings attributable to the Everside DPC clinical offering. We are not commenting on results of any particular employer client. This information does not constitute an endorsement or recommendation of Everside's services, nor does it quantify the value of Everside's services in aggregate or for any specific group historically or in the future.

Everside presented two methodologies to us for estimation of total cost savings related to Everside's DPC clinical offering as described below:

- Year-over-year methodology: compares actual claims cost to trended/adjusted claims cost from a base period prior to implementation of the DPC program.
- Control group methodology: compares actual claims cost of a cohort that opted in to the DPC program to a cohort that did not opt in to the DPC program on a risk-adjusted basis.

Both methodologies factor in the cost of the DPC program into the estimation of financial savings for employer clients and are described in greater detail in Sections III and IV.

Based on our review of materials regarding these two methodologies provided by Everside, we concluded that the methodologies are reasonable from an actuarial perspective. Everside's approaches are consistent with typical actuarial practices to estimate the net financial impact of their programs. Furthermore, we believe the methodologies are reasonable in terms of approach and assumptions used. However, the methodologies may produce results that are highly variable for individual employer groups based on several characteristics, such as demographics, risk profile, and most notably group size. In particular, we believe group-specific savings estimates are likely to be unreliable for groups with less than 500 enrolled members unless multiple years of experience are incorporated into the analysis.

Any reader of this report must possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions and the impact of these assumptions on the illustrated results. Milliman recommends that third parties be aided by their own actuary or other qualified professional when reviewing this report.

We are members of the American Academy of Actuaries, and we meet the qualification standards for performing the analyses in this report.

This analysis is subject to the terms and conditions of the Consulting Services Agreement between Everside and Milliman dated December 18, 2020. We understand that Everside intends to provide public access to this report through an internet link and therefore could be viewed by its prospective customers, competitors, potential investors, or other interested parties. We consent to this distribution if the work is distributed in its entirety. Milliman does not intend to benefit and assumes no duty or liability to other parties who review this work.

II. BACKGROUND

Everside offers primary care services to employers through health centers that it owns and operates. Employers pay Everside directly through monthly fees per eligible life and fixed monthly fees dependent on each client's circumstances. Everside may also pass through certain costs to employer clients for services arranged but not provided by Everside, such as laboratory tests. This arrangement is generally referred to as Direct Primary Care (DPC). The health centers are staffed by a variety of health professionals including primary care physicians, advanced practice providers, and various behavioral health providers, such as licensed clinical social workers (LCSWs). Providers are paid a salary rather than fee-for service. Everside health centers also have virtual care options available for accessing these providers.

The scope of health center services offered is comparable to other primary care offices and can be expanded to include behavioral health services and, in certain cases, musculoskeletal (MSK services), such as physical therapy. The patient-to-provider ratios are generally lower than traditional primary care offices and as a result, patient access to care is expanded resulting in shorter wait times for appointments and longer appointment times with a physician or other healthcare provider.

Everside generally structures its employer offerings in one of two ways:

- "All-in." The DPC offering is embedded into all coverage options provided by the employer. Therefore, all employees and dependents are eligible to use Everside DPC services.
- "Opt-in." The DPC offering is included with one or more coverage options offered by the employer or as a standalone option. While all employees and dependents are eligible for DPC services, only those choosing a benefit option that includes DPC are enrolled to use Everside DPC services.

Everside uses two different savings calculation methodologies that correspond with the structure and availability of data in each of these arrangements. For the "All-in" arrangement, all employees are eligible to use the Everside DPC offering, so there is no control group to use as a comparison against which savings could be measured. Therefore, a "Year-over-Year" methodology is used. The "Opt-in" arrangement creates a control group of employees and dependents who have not selected the DPC option against which potential savings in the DPC group can be measured. Therefore, a "Control Group" methodology is used.

We reviewed both methodologies as a part of this engagement. There are other potential benefits of Everside's DPC program such as increased access, improved clinical outcomes, increased employee satisfaction (qualitative) or reduced absenteeism (quantitative and qualitative) which are outside the scope of this analysis.

III. OVERVIEW OF “YEAR-OVER-YEAR” METHODOLOGY

The following steps are used in the Year-Over-Year methodology to determine employer savings and return-on-investment (ROI).

1. Determine baseline per member per month (PMPM) claims cost using 12 - 24 months prior to DPC health center opening.
 - a. Cap claims over a selected large claims truncation point.
 - b. Baseline claims may include or exclude Rx claims depending on data availability; future periods are measured consistently. The exclusion of Rx claims may understate or overstate savings.
2. Trend baseline PMPM claims cost to align with each DPC health center year to create yearly PMPM benchmarks.
 - a. A nationwide average trend rate is assumed based on published trend reports.
3. Adjust benchmarks for benefit relativities between baseline period and each health center year.
4. Subtract actual PMPM claims cost for each health center year from the corresponding PMPM benchmark to determine gross employer PMPM savings.
 - a. Health center year claims adjusted using same large claims methodology as under Step 1.
5. Subtract employer PMPM health center costs from gross PMPM savings to determine net employer PMPM savings.
 - a. Employer health center costs = employer covered DPC fees PMPM and any pass-through costs (e.g., for labs and drugs dispensed in the health center, calculated on a PMPM basis).
6. Calculate employer return-on-investment (ROI) as employer net PMPM savings / employer health center cost PMPM.
 - a. Examine both health center year specific ROI and cumulative ROI since inception of DPC program.

To illustrate this methodology, Table 1 presents a hypothetical example.

		Health center Year 1	Health center Year 2	Cumulative
(1)	Adjusted* claims PMPM for 12 months prior to health center	\$500	\$500	
	Trend Factor (5% annual hypothetical trend)	x	1.05	1.1025
(2)	Trended baseline claims PMPM	=	\$525	\$551.25
	Annual Benefit Change	x	0.975	0.975
(3)	Benefit Adjusted, Trended Baseline Claims PMPM	=	\$511.88	\$537.47
	Actual Adjusted* Claims PMPM	-	\$438.75	\$460.69
(4)	Gross Savings PMPM	=	\$73.13	\$76.78
	Employer Health center Costs PMPM	-	\$50.00	\$50.00
(5)	Net Savings PMPM	=	\$23.13	\$26.78
(6)	Return on Investment		46%	54%
			50%	

*Adjusted by capping large claims above a certain threshold (e.g., \$150,000) and including an incurred-but-not-paid (IBNP) estimate if necessary.

IV. OVERVIEW OF “CONTROL GROUP” METHODOLOGY

The following steps are used in the Control Group methodology to determine employer savings and ROI.

1. Determine health center year PMPM claims cost for members who opted into DPC for > 9 months (DPC group), and separately for members who did not opt into DPC for > 9 months (control group).
 - a. Cap claims over a selected large claims truncation point.
2. Determine normalized health center year PMPM claims cost for DPC group and control group by dividing the PMPMs from Step 1 by their respective concurrent risk scores.
3. Subtract normalized DPC group PMPM from normalized control group PMPM to determine gross employer PMPM savings for the health center year.
4. Subtract employer PMPM health center costs from gross PMPM savings to determine net employer PMPM savings.
 - a. Employer health center costs = employer covered DPC fees PMPM and any pass-through costs (e.g., for labs and drugs dispensed in the health center, calculated on a PMPM basis).
5. Calculate employer ROI as employer net PMPM savings / employer health center cost PMPM.
 - a. Examine both health center year specific ROI and cumulative ROI since inception of DPC program.

To illustrate this methodology, Table 2 presents a hypothetical example.

Table 2 Everside Health, Inc. Illustrative Control Group Methodology			
		DPC Members	Non-DPC Members
(1)	Adjusted* claims PMPM for 12 months of health center year	\$400	\$500
	Risk Score for Health center Year	/ 0.95	1.05
(2)	Risk-Normalized claims PMPM	= \$421.05	\$476.19
<hr/>			
(4)	Gross Savings PMPM (Non-DPC less DPC)	\$55.14	
	Employer Health center Costs PMPM	- \$50.00	
(5)	Net Savings PMPM	= \$5.14	
(6)	Return on Investment	10%	

V. CONSIDERATIONS

Although we determined that both methodologies are consistent with typical actuarial practices for estimating financial impact, we identified several possible limitations that should be considered by any user relying on results generated using Everside methods. These limitations include, but are not limited to, the following.

YEAR-OVER-YEAR METHOD

1. **Gross versus net savings.** The methodology calculates what it refers to as gross and net employer savings. Gross savings represent the estimated reduction in claims paid by the employer's third-party administrator (TPA) without consideration of the costs to the employer of the Everside DPC health centers. Net savings represent the estimated reduction in the employer's total non-administrative costs including the costs to the employer of the Everside DPC health centers. Because gross savings as calculated in the methodology excludes DPC health center costs paid by the employer, we believe it is possible for this amount to be misinterpreted. Net savings and employer ROI as calculated in the methodology are appropriate measurements of employer cost savings under the arrangement.
2. **Sensitivity to trend assumptions.** The resulting employer savings and ROI from this methodology are highly sensitive to the assumed trend rate used to project baseline PMPM claims to each health center year. This is particularly true when baseline PMPM claims are projected to multiple future years since any error in the trend assumption will compound over the length of the projection period.

In addition, secular trends for medical and prescription drug costs can vary materially by region of the country, payer, employer, and over time. Everside's methodology uses a nationwide average trend rate, which may be reasonable in some instances, but is likely a less accurate representation of market trend for any particular employer than using a state or even metropolitan statistical area-specific trend, or by using the baseline trend experience of the employer whose savings is being calculated. The use of a nationwide trend could overstate or understate the ROI.

3. **Statistical credibility.** The reliability of results will vary directly with the size of the employer group whose savings is being calculated. With more members, larger groups will have less claims volatility, and therefore higher statistical credibility. The opposite is true for smaller groups. When savings or loss estimates are near zero, they should include a statistical confidence interval or other adjustment that indicates there is a possibility of no savings or loss at all, and that calculated savings or loss could be the result of statistical fluctuations. This consideration is less of a concern for employer groups with multiple periods of DPC health center experience and larger covered populations but could be material for groups with limited DPC health center experience and smaller covered populations.
4. **Health Status and Demographic Changes.** The year-over-year method is applied over a multi-year time frame in which the composition of the covered population of employees and dependents for a particular group could change substantially. Employee turnover across all industries is almost 20%¹ annually, which implies that after only a few years, the cohort of employees being measured could be materially different than the baseline. These differences could manifest in age, gender, or health status differences. The longer the projection timeframe, the more likely it becomes that variability in these metrics significantly impacts the savings measurement. The absence of an adjustment for population mix changes could overstate or understate the ROI. There are several potential adjustments that could be made to account for population mix changes over time, but each one has limitations.

¹ <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2016-Human-Capital-Report.pdf>

- *Risk adjustment.* Using a risk adjustment software is an industry standard method to account for changes in member health status and demographics. However, it is possible that improvements in health status over time attributable to a better care deliver model, which in this use case, is precisely what is being measured could be erased by incorporating a risk adjustment approach.
 - *Age-Gender adjustments.* An alternative to risk adjustment is to adjust for the demographic mix changes using age-gender factors that account for the average health status differences between ages and genders. This would avoid the potential for negating legitimate DPC savings in the risk adjustment method, and at the same time, properly account for any change in demographics on average.
 - *Cohort measurement.* This method would limit the experience in projection years to only those employees that were present in the baseline period. However, as time passes, the cohort will decrease in size, increasing volatility of claims and decreasing statistical credibility. Changes in demographic composition will still occur but can be handled by combining this methodology with an age-gender adjustment.
5. **Program Changes.** Changes in the overall health benefits offering including, but not limited to, changes in third-party administrator, provider network composition and reimbursement, employee contribution requirements, and employee cost sharing parameters under non-DPC coverage, can affect the calculated employer savings and ROI over time. It is not uncommon for employers to make these changes to control costs or to remain competitive. Significant changes to the administration of the program could be accounted for with specific adjustment factors.

CONTROL GROUP METHODOLOGY

1. **Gross versus net savings.** The gross versus net savings consideration applies to both the year-over-year methodology and the control group methodology. Because gross savings as calculated in the methodology excludes DPC health center costs paid by the employer, we believe it is possible for this amount to be misinterpreted. Net savings and employer ROI as calculated in the methodology are appropriate measurements of employer cost savings under the arrangement.
2. **Statistical Credibility.** The control group methodology and year-over-year methodology have similar considerations regarding statistical credibility. The control group methodology lends itself to using a statistical approach such as a mean difference test, where savings could be determined as being statistically significant or not, and a confidence interval for the savings could be determined.
3. **Selection.** Because employees and dependents under the “Opt-in” arrangement have a choice to enroll in the DPC option, there is a potential for there to be selection differences between the control group and DPC treatment group. Therefore, it is possible that these two groups have different underlying demographic and health status mixes. Everside currently uses the Johns-Hopkins ACG system for adjusting for differences in risk between the control group and the DPC treatment group. Other risk adjustment systems may be appropriate for this purpose as well.

Although this is a reasonable approach for controlling for selection differences between the groups, there are other potential appropriate approaches for controlling for selection differences besides using the Johns-Hopkins ACG system. For example, other risk adjusters could be used, or a propensity score matching approach could be applied. It is beyond the scope of this paper to discuss the various methodologies available to control for selection and their potential impacts on the results for any given employer. However, having a valid approach to control for selection is critical to any savings methodology being actuarially appropriate in this context.

VI. DATA RELIANCE AND CAVEATS

In performing our analysis, we relied on data and other information provided to us by Everside. Specifically, we reviewed case studies of selected employer clients, data summaries, and methodology descriptions. We have not audited or verified the data and other information. We were unable to reproduce claims used in case studies because the underlying data was not available from Everside's data warehouse. However, we did evaluate the information for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We reviewed the case studies provided by Everside in both slide (PowerPoint) and spreadsheet (Excel) formats. Our review consisted of evaluating the methodology presented in either of these formats, verifying proper calculations, and evaluating the actuarial appropriateness of the methodology overall. We are only commenting on the generalized savings approaches that were provided to us. We are not commenting on results of any particular employer. Those reviewing Everside's calculations should take full responsibility for interpreting the results, which should be reviewed by someone knowledgeable in the areas of healthcare data and statistical methods. Milliman does not intend to benefit any third-party recipient of our work product.

While we find the methodology appropriate, all methodologies, algorithms and formulas are by nature assumption driven. We have no opinion on the assumptions chosen for any particular calculation of savings done for any employer group.

This review incorporates Milliman's experience in working with similar programs that rely on claims data. Actual experience will differ from the savings we reviewed in various case studies. Actual savings will differ from the sample results we have reviewed for many reasons including, but not limited to: member characteristics, changes to Everside's program, benefit designs that influence utilization, and physician practice patterns, as well as other random and non-random factors. It is important that actual experience be monitored and that appropriate adjustments be made to the methodologies.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this paper are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis.