MILLIMAN WHITE PAPER

Benchmarking cost and utilization of direct primary care services

Commissioned by Nice Healthcare

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Direct primary care is a healthcare model that provides a broad range of primary care services through a direct contract between the provider and employers or patients, with no fee-for-service costs or third-party billing.

Direct primary care (DPC) models are relatively new and evolving. They offer an alternative to traditional primary care models, with the goal of improving the provider-patient relationship and reducing the fragmentation of care. It is hoped that this improvement in primary care delivery may lead to broad-based healthcare cost savings.[1]

Most DPC models provide coverage for a broad range of primary care services for a monthly or annual fee ("membership fee") paid directly to the DPC provider, with no payment to providers from insurers or other third parties. These models can vary broadly in their structure and financing, with some offering memberships directly to patients and others offering group memberships to employers for their employees. In most cases, the memberships cover all primary care services at no additional per-service cost beyond the membership fee.

Nice Healthcare (Nice) describes itself as an integrated clinic addressing primary care, mental health, physical therapy, and certain prescription drugs through a technology-enabled network of in-home visits and virtual care options.[2] Nice contracts with employers to provide this coverage for their employees. Consistent with the traditional DPC structure, Nice offers its services for a flat rate per member per month (PMPM) or per employee per month (PEPM) paid by the employer, with no additional per-service costs or premium charged to members.

When Nice sells directly to self-funded employers, the DPC membership fee typically covers the cost of the subset of healthcare services Nice offers. For fully insured employers, Nice coverage becomes a supplemental add-on intended to reduce employee out-of-pocket costs and improve the healthcare experience, while helping to control premium increases through a reduction in claims paid by the employer coverage. Employers may also realize additional cost savings through reduced premiums by switching to an insurance plan with higher member cost sharing on the services that members have access to through their Nice membership.

Nice engaged Milliman to benchmark the average cost of traditional healthcare services and prescription drugs that Nice could potentially address for commercially insured patients using a proprietary nationwide research database of claim and enrollment data. These benchmarks—which represent cost and utilization data for a population of approximately 58 million member months of exposure for claims incurred in January through October 2021—provide an understanding of the fraction of commercially insured members that would typically utilize the services Nice can address and the typical claim costs associated with those services in a commercially insured large employer group population. These benchmarks do not include the cost of Nice membership fees, which would need to be taken into account to understand the full impact Nice has on the total cost of care. Milliman has not reviewed Nice's impact. This paper is not intended to endorse Nice Healthcare or imply that Nice will generate total cost of care savings for any particular employer.

Summary of results

Nice aims to address a spectrum of primary care services, including primary care office visits, laboratory and imaging services, behavioral health, physical therapy, care guidance, and certain prescription drugs. Services are provided virtually through

[1] Busch, F., Grzeskowiak, D., & Huth, E. (May 2020). Direct primary care: Evaluating a new model of delivery and financing. Society of Actuaries report. Retrieved September 13, 2022, from https://www.soa.org/49c889/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

[2] Nice Healthcare. Our mission. Retrieved September 13, 2022, from https://www.nice.healthcare/about.

the Nice Healthcare App or in the patient's home.[3] Throughout the rest of this paper, we will refer to the services and drugs that can be addressed by Nice as "Nice services." The PMPM values for Nice services in this paper represent the expected cost for all the services that Nice could address, using the prices that are typically paid by insurers or self-funded employers for those services.

We summarized total cost of care benchmarks for services included in a traditional large employer comprehensive healthcare plan and then isolated the subset of services Nice can address, using service and drug codes Nice provided for that purpose. The total cost of care benchmarks include all prescription drugs and medical services at all facilities. Benchmarks for Nice services reflect the historical utilization and cost for the services Nice can potentially address, as reflected in the claim database, which as noted previously represents a typical large employer commercial population on a nationwide basis. In an actual employer group that elects to provide Nice as an option to its employees and their dependents, the cost and utilization of services Nice replaces and the total cost of care would be expected to differ from these benchmarks for a number of reasons, including but not limited to the following:

- Not all members will choose to utilize services through Nice and may instead choose to seek care through other providers covered by their existing insurance plan. Additionally, those members who choose to use Nice for some services may still choose other providers for some services that Nice can also address.
- The cost of Nice services will likely differ from the cost of services provided under an insured health plan because of Nice's integrated network, mix of in-home visits and virtual care, and the fact that it is offered directly to employers, with no third-party overhead.
- Nice patients may exhibit different utilization patterns due to Nice's mode of healthcare delivery, accessibility, care patterns, and referral processes. For example, the Nice model of care will likely result in more in-home visits and telehealth and fewer office visits.
- Nice patients may also use more services to the extent that they are no longer subject to deductibles, copayments, coinsurance, or other member cost sharing.
- For any given employer, the covered population may differ from that in our research data set. For example, the population may have a different mix of members by age, gender, or geographic area, which would affect cost and utilization.

We have not attempted to adjust for these factors in this study. Instead, we provide benchmarks for the cost and utilization of services that Nice can address under the status quo, where those services are provided as part of a typical employer health plan for the average population in our research data set.

Figure 1 provides a summary of the total allowed cost of care and the allowed cost of the subset of services Nice can potentially address. The allowed costs in this chart represent nationwide average claim costs for a typical large employer insurance plan, including plan payments and member cost sharing. As shown in Figure 1, Nice services make up approximately 12.2% of the total allowed cost of care in the benchmark data.

FIGURE 1: SUMMARY OF BENCHMARK ALLOWED COSTS PMPM

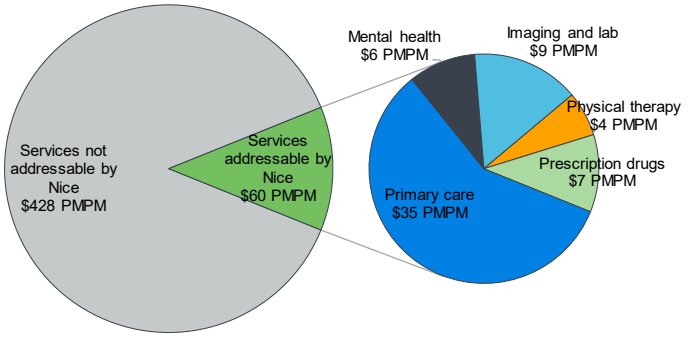
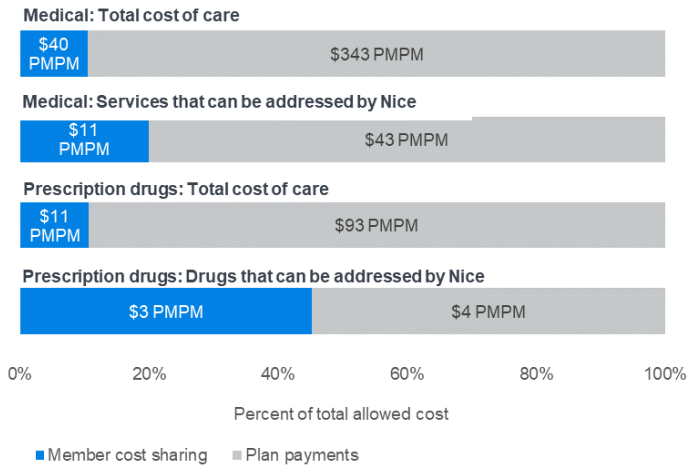


Figure 2 provides insight into the composition of allowed cost from Figure 1 by comparing the average portion paid by the member (in the form of deductibles, copays, and coinsurance) versus the portion paid by the insurance plan. As shown, in a traditional insurance plan, the services Nice can address typically require higher levels of member cost sharing as a proportion of total cost than the full package of benefits. This may be because the services that Nice can address are lower-cost, and those services are typically subject to member cost sharing that is fixed in nature (that is, deductibles and copays). However, under the Nice model of care, members would incur little to no cost sharing for those services.

[3] Nice Healthcare. Nice's primary care services. Retrieved September 13, 2022, from https://www.nice.healthcare/services.

FIGURE 2: COMPOSITION OF ALLOWED COSTS PMPM



Members do not use services and prescription drugs that could be addressed by Nice equally at all sites of service.[4] Our study found that the majority of services performed at urgent care facilities or provided via telehealth are services that can be addressed by Nice. Figure 3 breaks down the composition of services by place of service.

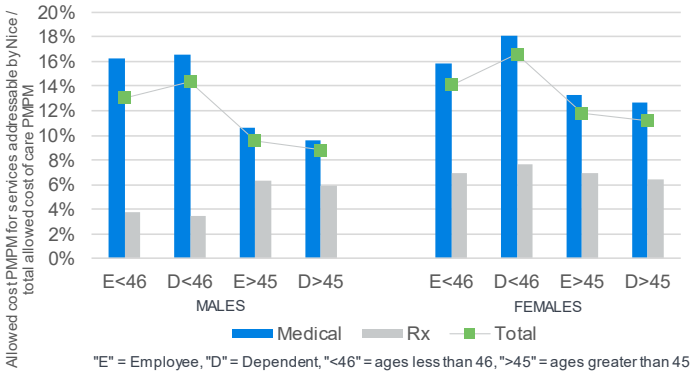
FIGURE 3: COMPOSITION OF BENCHMARK ALLOWED COST PMPM BY PLACE OF SERVICE

	PMPM Allowed		
Place of Service	Cost of services addressable by Nice	Total cost of care (TCOC)	Percent of TCOC addressable by Nice
Telehealth	$7	$8	85%
Urgent Care	$2	$3	68%
Office	$31	$70	44%
Outpatient Facility	$7	$97	7%
Prescription Drugs	$7	$98	7%
Emergency Department	$1	$13	5%
All Other/Unknown	$6	$193	3%

A DPC delivery system has the potential to fundamentally change the distribution of healthcare services due to differences in its delivery system, care and referral patterns, and the induced utilization associated with lower levels of member cost sharing. Many believe that DPC offerings can have a significant impact on long-term costs and patient health outcomes,[5] which could mean changes in the composition of healthcare services overall. This study relies entirely on the distribution of services for a commercial population enrolled in a comprehensive health insurance plan. Further analysis would be needed to understand how the introduction of a DPC option would influence consumer behavior and health outcomes.

Figure 4 illustrates how benchmark allowed costs for Nice services in proportion to the total cost of care vary by demographic. In general, the proportion of total cost of care addressed by Nice services was higher for younger members and lower for older members in our benchmark data. This is expected, given that older individuals use more inpatient and other facility services that Nice does not address. For prescription drugs, this same pattern holds for females, but not for males, likely driven by differences in the mix of drugs used by each age and gender cohort.

FIGURE 4: NICE PROPORTION OF TOTAL ALLOWED COST OF CARE BY DEMOGRAPHIC

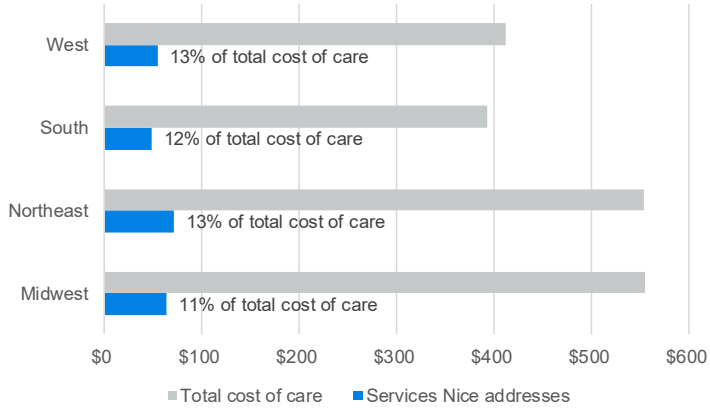


Results were also reviewed by region, as shown in Figure 5. While the total cost of care varies widely by region, the proportion of services that can be addressed by Nice varies by just two percentage points across regions in the benchmark data.

[4] Location was identified using a combination of the Centers for Medicare and Medicaid place of service and other logic developed by Milliman to identify telehealth claims.

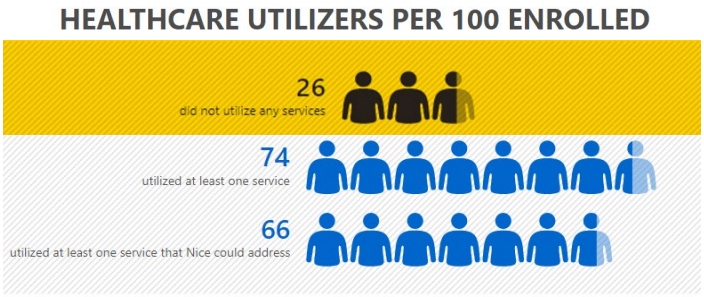
[5] Busch, F., Grzeskowiak, D., & Huth, E. (May 2020). Direct primary care: Evaluating a new model of delivery and financing. Society of Actuaries report. Retrieved September 13, 2022, from https://www.soa.org/49c889/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf.

FIGURE 5: PROPORTION OF TOTAL ALLOWED COST OF CARE NICE COULD POTENTIALLY ADDRESS - REGIONAL COMPARISON



Another key consideration is the number of people that Nice services "touch" in relation to the total population covered. As shown in Figure 6, we found that 26% of members in our benchmark data did not use any services or prescription drugs during the time frame analyzed. Of the 74% who utilized at least one service or prescription drug, 89% had at least one service or prescription drug that could be addressed by Nice. Although the total cost of services that could potentially be addressed by Nice is a small fraction of the total cost of care, the services that Nice can address were utilized by the vast majority of the population utilizing the healthcare system.

FIGURE 6: SUMMARY OF MEMBERS UTILIZING SERVICES AND PRESCRIPTION DRUGS



Data and methods

The benchmark data used in this analysis is from Milliman's Consolidated Health Cost Guidelines Sources Database, which includes membership, medical claims, and pharmacy claims for individuals enrolled in commercial large group coverage (both self-funded and fully insured). We used claim and enrollment data from January 2021 through October 2021, with claims paid through December 2021. We limited our analysis to claims that had a positive allowed amount and a matching membership record in the month a claim was incurred. We removed members who did not reside within the United States, members without both medical and pharmacy coverage, and members who had capitation arrangements for any of the services Nice can address, because the allowed amounts on those claims are not expected to reliably represent the cost of the service. Our ending data set included approximately 58 million member months and more than $28 billion in allowed claims.

Services that could be addressed by Nice were defined using a subset of procedure codes supplied by Nice representing the services that Nice can address. These are primarily related to laboratory and imaging services, behavioral health, physical therapy, and other primary care services. Prescription drugs that could be addressed by Nice were identified using a list of national drug codes that Nice supplied.

While large in volume, this data set may not be representative of the nationwide average large employer population to the extent that the data included in our study does not represent the demographics, geography, benefit plans, or other characteristics of the full population. We have not attempted to adjust the data for seasonal patterns in claim cost levels or to apply completion adjustments to reflect additional claim runout beyond the end of 2021. Results for the full calendar year and with additional claim runout may vary somewhat from these results.

Caveats and limitations

We relied on the data and other information from Milliman's internal research databases for this analysis, which is sourced from our clients and other vendors and then processed, cleaned, and reviewed for quality before being released for consultant use. We have performed a limited review of the data and other information used for this project to check it for reasonableness and consistency, and have not found material defects in the data or information used. If there are material defects in the data or other information, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Milliman tools have been used to produce these results. We have reviewed the tools, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice.

Differences between benchmarks in this analysis and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain

that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent the assumptions in this analysis are not realized.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. The authors of this paper are members of the American Academy of Actuaries, and meet its qualification standards to perform the analysis and render any actuarial opinions contained herein.

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