accenture

The cost of healthcare system complexity

AHIP Webinar

Audio Transcript

Monica: Hello and welcome to today's webinar *The cost of healthcare system complexity*. Before we get started, I'd like to review a few housekeeping details. Today's webinar is being recorded and an online archive of today's event will be available a few days after the session. If you have trouble seeing the slides at any time during the presentation, please press "F5" to refresh your screen or "command R" if you're using a Mac.

You may ask a question at any time during the presentation by typing your question into the Q&A box located on the right side of your screen and pressing enter. And finally, I'd like to remind you of AHIP's anti-trust statement located on the link just below the slide viewer. As always, we will comply with that statement. Among other things, the anti-trust statement prohibits us from discussing competitively sensitive information. We're very fortunate to have with us today JP Stephan, Renee Ghent, Shawn Wagner and Julian Feeley. And at this time, I would like to turn the floor over to JP to introduce the presentation and panel participants.

JP Stephan: Welcome. Thank you, Monica. Welcome everyone. My name is JP Stephan. I'm a Managing Director at Accenture and I lead our health customer engagement practice. I help our clients transform their organizations to better engage their consumers. And today I have the pleasure of being your moderator for this discussion on healthcare system literacy and complexity.

We have a great agenda in store for you that has three parts. First, we will share insights in research from Accenture's latest study. Second, I will be monitoring a panel discussion around this topic of healthcare system literacy taking three different perspectives: one from a leading

healthcare organization, another from an innovative full stack insurance startup, and the third from insightful consumer and industry research. Finally, we will wrap up with a Q&A session.

As Monica mentioned, throughout the presentation you can type in questions, and we'll look to address those at the end of the discussion. Now I'd like to introduce our panelists. We have Renee Ghent, with Aetna, a CVS health company. Renee serves as the chief digitization officer at Aetna where she is charged with both reimagining and reinventing the constituent experience across the Aetna organization, leveraging data and digital technologies. Renee has an extensive background in IT and digital solutions, and she is committed to embedding a "digital first" mindset across the organization.

We also have Shawn Wagner. Shawn serves as Bind's Chief Revenue Officer. Shawn co-founded Bind with a small group of innovators back in 2016. Before founding Bind, Shawn led a healthcare technology company that was later acquired by United Healthcare. Shawn also served as an officer in the US Army in the Iraq War.

So, Shawn, thank you for your service and thanks for joining us today. Last but not least, I'd like to introduce, Julian Feeley. Julian is a business strategy manager with Accenture. He specializes in growth customer engagement, as well as innovation.

Julian is a key contributor to Accenture's thought leadership and research, and he will be sharing our research here on healthcare system literacy.

Thank you all for joining us. I'd like to turn it over to Julian, to share some consumer insights.

Julian Feeley: Thank you, JP. To provide a brief background on the research, there's a lot out there on the subject of health literacy. We wanted to focus on healthcare system literacy specifically, and the ability of consumers to navigate this complex system to meet their care needs.

There's a lot of data and information on the following slides that we'll go through. I want to structure our discussion around three key insights about the behaviors of consumers with low health care system literacy and the impact that has on our healthcare system in terms of costs and spending. Then we'll look at some of the underlying drivers of those behaviors that will lead us into recommendations moving forward.

This research is largely based on a recent study of over 12,000 US healthcare system consumers. One of the key areas that we asked them about was their understanding of the healthcare system in terms of being able to correctly define common terms, such as premium, deductible and copay.

We also wanted to know if they understood core concepts such as the difference between “in-network” and “out-of-network.” The goal was to understand their ability to navigate the system to have their needs met.

Based on that research we've segmented consumers into four groups around healthcare system literacy: no experience, novice, proficient and expert. We've been running this study for several years now, and if you look at the left-hand side of the page for 2017, you can see that there's a pretty even split between what we've categorized as low health care system literacy consumers—those with no experience or who are novice—and high healthcare system literacy consumers, who are either proficient or expert. If you look to the right-hand side of the page and you fast forward to 2021, it's a very different and changing picture.

Today more than 60% of consumers have low health care system literacy, and conversely, fewer than 40% are highly literate in the system. If you do the math, that's a 20% decrease in health system literacy over just the past few years based on the same survey, asking the same questions.

So, the first insight I want to talk about involves the behaviors of those with low health care system literacy, and one thing that stood out is they are much more likely to have used the emergency room for care in the past 12 months.

When we did the analysis, we broke it out based on those with chronic conditions on the left-hand side of the page and those who were generally healthy on the right-hand side to make sure that the differences in their use of the emergency room weren't being driven by health status. If we start on the left with chronic consumers, low healthcare system literacy folks are in purple.

Those with high system literacy are in gray, and for chronic consumers those with low system literacy are twice as likely to have used the ER. If we look to the right-hand side for those who are generally healthy, naturally overall use on aggregate of the ER is lower, but the difference between those with low and high system literacy is even more pronounced.

When you round the numbers, those who are generally healthy, but have low health system literacy, are about three times more likely to have used the emergency room for their care.

The second insight I want to focus on is that there's a tremendous cost and spend impact tied to low healthcare system literacy. We honed in on one area of that, around the use of the emergency room, and identified nearly $50 billion in annual avoidable medical spend across the United States.

Again, with this analysis, we segmented the data based on those with chronic conditions or those who are generally healthy. If you look at the page, the darker purple is the current emergency room spend of those with low health care system literacy. The lighter purple is the spend if those consumers used the emergency room at the same rate as those with high system literacy. What we're doing here is controlling for the impact of low system literacy on the use of the ER and seeing what it would look like if that were removed as a factor and as a barrier to the way that consumers make decisions about their care. To do the analysis, we assumed that excess emergency room visits among those with low system literacy would be diverted to other, more appropriate channels like the physician's office or urgent care, or virtual care.

If you look at the page that drives $42 billion for chronic consumers and an additional $5 billion for those who are generally healthy, that adds up to the $47 billion in annual avoidable medical spend if low system literacy is removed as a factor.

The third insight I want to focus on is the key question here. What's driving this difference? Why is this happening? And ultimately the data shows that those with low system literacy are using the emergency room as the path of least resistance. It's become the default in a complex system where options aren't clear.

If you look at the data on some of the specific drivers and you look at the differences between those with lower or higher healthcare system literacy, those with lower literacy in purple, here, really feel that they don't have the information to find the doctors or the treatment that they need when they need them.

They can't use their preferred channel to find care. They feel it takes too long to get care. And so, in a world like that, the emergency room stands out as a clear option. It's always there. It's dependable. It's always open and you can rely on it for your care needs when, outside of that option, there's this broader complexity throughout the healthcare system.

In terms of the path forward, leaders should focus on four key areas that were identified based on the research. First, simplify and innovate product designs to try to reduce the healthcare jargon and the complex roles that consumers need to understand to be able to navigate their care. Second, drive price and transparency to make options and choices clear and create more of the shopping experience that consumers get in so many of the other industries. Third, drive provider collaboration to align incentives and help make patient options clearer and closer to the point of care where providers have a lot of influence and can make sure those communications and directions align. Fourth, underpin all of this with human-centered design.

The goal is to create a more intuitive system and interweaving that with all the other areas on the page. Instead of attempting to mold consumer behaviors to a complex, legacy healthcare system and trying to train customers to navigate it, providers should look at ways to redesign the system so that it works for consumers.

To conclude with the upfront research component of this, we talked about the growth in low healthcare system literacy. We discussed the impact this has on consumer behaviors and the greater use of the emergency room as a default for care. We talked about how that drives spending and costs and the overall healthcare system. And then we talked about some of the underlying drivers of these behaviors and the recommendations moving forward. So, with that JP, I'll hand it back to you to open up our panel discussion.

JP Stephan: Awesome. Thank you, Julian. A lot of information there to unpack, we'd love to engage now in the dialogue around these findings, unpacking these in three parts. The first is understanding the problem. What challenges do we face with healthcare system literacy? Second, let's talk about solutions, either existing solutions or future solutions. And then finally, I'd love to hear from the panelists on how we think about the future and the path forward.

Before we dive in, Monica, I would love for you to perhaps restate how to post questions. I see that we have over half a dozen questions posted already, just throughout this discussion, so we could seek to field those.

Monica: Yes. Thank you. As a reminder, you may ask a question at any time during this presentation or during this panel discussion by typing your question into the Q&A box located on the right side of your screen and pressing enter, and we will address the questions at the end of the webinar. Thank you so much.

JP Stephan: Great. Thank you, Monica. Well, group, what are your initial reactions? Renee, I know that this has been a topic of discussion in the industry for quite some time, what are your reactions to these insights?

Renee Ghent: First, thanks to JP for having me here. I'm looking forward to a great dialogue with Shawn and Julian. I'll start with three things: one reaction and then a couple of observations. First, I'm not surprised. This is an industry-wide challenge and I don't think this data probably surprised anybody. There was an earlier slide, I think one of the first slides that Julian shared, which talked about the proficiency of the population. Shawn and I commented on this earlier when we were prepping. I'm surprised at how high that percentage was. I think it was 13% expert and 26% proficient. What do you think about that? 39%. So even though it went down from 17 to 21, that's still a pretty high percentage. So maybe that's optimism. Maybe that's just sort of how the survey hit certain populations. That's certainly one observation. Here's a little story. The last year or so with COVID, we all experienced electives [elective surgeries] being put off. Members were finding less care. There was an

interesting observation in here, in some metrics around individuals having noted that my healthcare company isn't helping me find care. Well, during COVID when that care was not being used as much, our NPS score, which is a measurement of consumer satisfaction, actually went up. We saw a direct correlation of fewer people finding care during COVID.

Lastly, I would just say I loved the C-suite recommendations because they're all the things we've been focused on for the last couple of years, and we've got some really good momentum behind them, so it was nice to see a little bit of the validation.

JP Stephan: Awesome. Well, thanks for sharing that, Renee. Shawn, your perspective as a company that's looking to rewrite how we do healthcare insurance. What are your reactions to the insights?

Shawn Wagner: Sure. Again, thanks for having me, JP. I'm proud to represent Bind and all we do for thousands and thousands of Americans as we speak.

So, both as Bind and as an innovator, whether you're innovating externally and starting something new, or you're part of a larger organization, and you're an "intrapreneur," I think I would call these findings gold. These findings say to me nothing but opportunity, especially when you think about these findings and their downward trajectory. They're not heading in the right direction, which means they're even more golden.

So, as either an intrapreneur or an entrepreneur, this is a huge area of opportunity. That's what I would be taking away from this. The challenge is how do I turn this opportunity into something valuable to the entity I'm either creating or the entity I'm supporting in innovation.

JP Stephan: Yeah, that's a great point, Shawn. The trend wasn't headed in the right direction for over a decade, we've seen start-ups or innovators or even organizations from outside of health that are looking to disrupt this. What makes it so challenging to navigate this complexity? Shawn, I'll just follow up on your initial remarks there. What makes it so challenging or why haven't we cracked this nut yet?

Shawn Wagner: I'll just pick up on the biggest challenge at any opportunity, which is how do I monetize it, essentially? And monetization goes back to business models. I was fortunate to be able to learn business model thinking from the great disruptor Clay Christiansen and his point of view was everything comes back to the business model. The challenge with health system literacy is how do I couple improving it with a business model that I can get investments behind to the tune I need to sustain the innovation because it's going to take more than a couple of months to crack this problem. So, I need to align a business model to the opportunity. Today, if you just look at the value chain of the business models, I think the current business models are thriving despite this challenge. So, if you look at quarterly earnings from for-profit

provider systems or for-profit health insurance entities, if you look at not-for-profit entities, the business models are not in a downward trajectory, they are thriving. I believe the fundamental challenge is how do I connect this opportunity to the business models that are in play and show how I can improve the performance of the business model by investing in this, or do I have to think of a new business model to monetize this opportunity.

I hate to use a crazy term like business model as a fundamental challenge, but I do believe that Clay Christianson was right, that it all comes down to the business model.

JP Stephan: That's a very interesting perspective. So often, we try to solve it solely with technology or by trying to address the experience layer of that technology or operating model. But we don't necessarily seek to address the business model, which is a fundamental change. As an insurance company, Renee, just interested in your reactions to Shawn's observations.

Renee Ghent: I couldn't agree more. I feel like we do try at times to lead through technology and we've got to start with our business transformation. Re-inventing, re-imagining, are two words that we're hearing a lot. How do we take this into the future? There are a few other things I would add to what's driving the complexity here. First and foremost, I think a big part of this is consumer choice, which is leading to the complexity of products and benefits.

Let's think back: many on this call can probably recall when we were growing up, you'd go to your family doctor. You went to your family doctor and it was pretty simple. It was a $5 copay. You went to the doctor; it was a $5 copay. You went to the pharmacy; it was a $5 copay.

If you went to a specialist, maybe it was a $10 copay. With all of the consumer-driven health plans, the federal regulations that are out there, we now have to build for every exception. It's just a fact that our products are so much more complex today. Not only for our members, but also for our providers, for our customer service reps, for those folks that are selling.

We've created this complex product environment because it allows for stability and choice. I would say that that's one thing driving complexity. The other thing that I want to spend a minute talking about involves comorbidities. A recent study from the CDC said six in 10 adults have a chronic illness and four in 10 have more than two. So, think about that individual who has an illness and they're trying to navigate this healthcare system. They're trying to deal with two and three and sometimes four different illnesses that they're trying to navigate.

I'll share a quick story to hit home on this. I've lived in the healthcare environment for 32 years. I've worked at Aetna for 32 years. I've worked in technology. I get the ins and outs of the system pretty well. I had a sister that I lost about four or five years ago. She

had a brain tumor, but she also was a diabetic. She also had a neck fusion. She also was depressed. She also had a mental illness and, it was myself and my family that navigated her healthcare system for her and her journey. We had to bring the list of prescriptions from doctor to doctor. I think living in this world of comorbidities in an already complex healthcare environment, is also adding to how hard it can be to navigate the system.

JP Stephan: It comes back to the product and it's not just the financial product. Thank you for sharing that story. It's our health, it's our loved ones, so it goes beyond just an insurance product or a financial instrument, to something that has an impact on individuals. Julian, when we looked at the research you shared from 2017 to now, the trend has gone in the wrong direction. What impact did COVID have on that? Is that a reason for the increase in low literacy or what's your hypothesis?

Julian Feeley: That's a great question because if you look at that change from 2017 to 2021, an obvious idea to fall back on is that COVID has made healthcare system literacy worse, but it turns out that's not the case. When we look at the data and run the analysis every year, it's steadily decreasing year after year. There's no jump or substantial difference in the trend between 2019 and 2020 after the onset of COVID-19. Similarly, it's not as if COVID is driving higher use of the emergency room. Most studies show that ER use in 2020 decreased, relative to prior levels. So, it seems it's a fully separate issue in and of itself. Of course, COVID impacts it, but it's not being driven that way. The only other piece of data that I'd just briefly highlight is that there does seem to be a relationship between health system literacy and vaccine hesitancy.

Those with the expert level of healthcare system literacy or those in that segment are 25% more likely to either have received or been planning to receive the COVID-19 vaccine relative to those with lower system literacy. So, it does have a relationship to some of the broader questions about vaccinations that will impact the healthcare system and utilization moving forward.

JP Stephan: Thanks, Julian. To Rene's point, products aren't becoming simpler. Our data shows one of the impacts is this literacy and then the behaviors associated with it. Shawn, you highlighted the fundamental issue of our business models in the system. What else could be contributing to this decline? Any perspectives there?

Shawn Wagner: Sure. I think, going back to Renee, when you look at the product evolution, we continue to increase deductible layers. We continue to rely on co-insurance layers and we now start to run out of room there. So, we start doing things like narrowing choice on the provider side, narrowing networks, which only further complicates the situation.

I think the product construct continues to create challenges for people. On the flip side of things, what if you're on your

phone trying to figure out what to do about something? You go to the local provider organization in your neighborhood, or you know a family member that works there or you have some other affinity to them. I haven't seen a lot of attempts by anyone on the provider side to say, "Hey, don't come to my emergency department." You often see the opposite: "Come to my emergency department because my wait's only two minutes." So again, I hate to keep going back to the business model, but I think there are challenges and the product innovations that we're seeing are not trying to change this. Throwing up a dashboard on the wait time to the ED is not helping people get to the appropriate side of care. I think we have challenges in the innovations people are putting forward. They're sustaining the business models.

JP Stephan: Right. It comes from an insurance perspective back to the product. Renee, I know a big focus over the past several years has been to make the language consumer-friendly and make it understandable to the consumer. It sounds like there's also something more fundamental around changing the product. Why is it so difficult to change the product in this industry?

Renee Ghent: There are multiple factors. Let me just put a few out there. I'm sure I'm missing a whole bunch, but just from my experience here, one is a lot of federal regulations. There is just so much that is federally regulated. On top of that, a significant portion of our clients, our plan sponsors, are what we call self-insured. They're assuming the risks for their employee bases. There's always, "Here's what we're able to do from a regulation perspective." And then there's what the plan sponsor wants to do. And then within Aetna, we're a 160-year-old company and it's really hard to change those legacy systems for an existing product.

It's easier to create a brand-new product, but then you still have all of these other challenges. But product changes, product innovations, product design in systems that are several decades old – it's hard. And there's a cost. John, I think you mentioned this a little bit earlier when you were talking about the business model. It's hard to do. It's expensive to do. And although we tend to make small improvements there, I go back to the re-imagine, redesign, re-invent that needs to happen. I think that we're started on a journey to get there. We're starting to think about more of a modularized, simplified product. Bu there are several barriers in place to doing that quickly. I'm not saying it can't be done, but to do it quickly and at an acceptable cost is hard.

JP Stephan: That's a great perspective. Julian, you described the impact on one behavior of ER usage. What are your thoughts on the other impacts? Whether it's the medical cost or administrative costs, what are some of the hypotheses we have around the potential impact of low literacy?

Julian Feeley: We've done research and analysis to show the impact on at least one area of administrative costs, and it's also significant. As you might

imagine, those with low health system literacy have more trouble navigating healthcare. They have more questions that need to be answered, and one way this manifests itself is that they tend to call customer service much more often. We looked at payer customer services specifically, and it's much higher than their peers with better healthcare system literacy. This cost has also started to balloon over recent years.

In 2018, we had attributed about $5 billion annually, just on the payer side, that we were looking at. In terms of costs attributed to customer service use among those with low health care system literacy, looking at the latest data, our analysis from 2021 shows it's about doubled to over $10 billion because there are a greater number of consumers in that lower healthcare literacy category. And the difference in behaviors seems to be increasing as well.

JP Stephan: And that's just the payer side. You can imagine that on the provider side of the system they're also receiving customer service calls, billing, coverage, et cetera. And not to mention the administrative cost of it, but who wants to call customer service over a bill or coverage? So, we've looked enough at the problem. Let's move forward to the solutions.

We've talked about the product being at the center. Shawn, you introduced Bind as essentially looking to reinvent the health insurance product. Can you tell us a little bit about what opportunity Bind saw with the health insurance product and maybe address some of your business model concepts? How are you rethinking, health insurance?

Shawn Wagner: Sure. Those are all very bold statements. These things are like 20-, 30-, or 40-year arcs that we're talking about. So even though that bold statement is out there, we recognize that we've got dozens and dozens of years here to do this, but where do you start?

I think expecting people to suddenly have a breakout of health literacy with concepts that don't make a lot of sense to them is probably not a good idea. If you're going to change health insurance, you probably need to change the product itself.

You're not going to navigate or concierge your way out of this. You're not going to tech stack your way out of a bad insurance product from a consumer perspective. Co-insurance that gives me certainty only after I've already made a decision and consumed things, and then later I understand what my financial result is: fundamentally that is not a good concept if you want to get people to make decisions that benefit themselves and you as the risk bearer. So, we did away with things like coinsurance, deductibles from a risk pool perspective and utilization. Yes, they do change utilization patterns.

Sometimes that's good. Reducing the use of imaging for headaches. Reducing the number of people that have diabetes going to see their

endocrinologist to titrate their meds. That's not a good use of a financial incentive. So, we removed deductibles as well. And when you do that, you're able to take advantage of what we've always believed in people: we believe that people, if they feel comfortable and they're given good information—valuable information—they will make good decisions for themselves.

And those decisions that benefit themselves will also benefit their employers. If they're a self-funded plan sponsor; if they're on a fully insured plan through their employer. So that's the fundamental nature we wanted to dig into: was there a tremendous opportunity here?

And it's not that they're not able to make decisions, it's that they're not given a product about which they can be informed and make decisions. So, we've reversed that and said, let's start with a product that people feel competent in. They understand it. It's just a product with a bunch of copays or price tags.

There's no deductible. No co-insurance. And when you do that, people can say, "Oh, I get that. It's like it used to be. I've got an insurance card. I can access care. And I pay when I access it." And then when you start with that, you can layer on what people want. I want it personalized to me and I want to grab my phone and learn things and see information. And you can do that when you remove co-insurance deductibles; you can render something in a search box, a result, and people can see information and make good choices. So that's what we saw as an opportunity. That's what we focused on. And, it has worked quite well.

JP Stephan: Thanks for sharing that, Shawn. Redefining the product. Renee, we've talked a lot about product, but to pull this off requires a lot within a health insurance organization and other departments. You have operations, you have digital, you have technology. What's required to coordinate this and make it easier on the consumer, within an organization?

Renee Ghent: The first thing I would put out there is we have got to move away from the transaction-based and move to the experience-based and that's not something that we've done. As you can imagine within Aetna—not even in the broader CVS enterprise—but we're about 50,000 to 55,000 employees within Aetna alone, a $70 billion company.

So, when you think about all of the different organizations that need to come together, historically everybody has been sort of off on their island and doing their own thing. We made a very deliberate decision to form the new Aetna digitalization organization that I lead. And our focus is on the member, provider, and the experience of those constituents.

We do that with a lens. It has to be connected. It has to be personalized. And it has to be something that we look at holistically across all of our lines of business. So even though today, we

run a government business with Medicare and Medicaid, and we run our group business with commercial, my team is responsible for working across all of our business lines and creating a single experience roadmap.

Julian mentioned human-centered design. We use that design thinking: put the consumer at the center of every decision you make. What does that experience look like for that individual? I would say that our agile practices allow us to do this, and we work closely with our analytics team and our data team and our digital team, our IT organization. But the shift we're starting to make now, it's not a whole bunch of little individual projects with everybody off doing their own thing. We have a strategy. We have an experience that we want to have for our members and our providers. And we have a prioritized investment, and we have a governance process around it that allows us to look at it holistically across the organization. I will say it has not been easy.

Shawn mentioned business model changes earlier, operating model changes. This is a cultural change as well. Everyone wants their own thing. You've got to bring all that together. So, we've been successful at the start of our journey, but it's been year one of bringing this organization together.

I mentioned earlier, we're a really big company, but we have to use that to our advantage as well. Size and scale. We have a ton of data. We have a lot of insights. We've got an entire enterprise insights organization that helps us understand the voice of the customer and helps us in how we think about prioritizing the things that we need to implement. We need to move away from all these individual transaction-based priorities and think about the members holistically. What does that experience look like? That is where our focus is moving toward.

JP Stephan: Several great points, Renee. Shawn, I like your comments around the business model, what you describe as a fundamental operating model change that needed to happen with your organization and how you approached investments and initiatives. Renee, can you share perhaps some learnings from some of the initiatives that you've implemented or what can you share with the group in terms of some of these early innovations that you've sought to implement in the organization?

Renee Ghent: I would say, first, it's really hard. And you need to acknowledge the amount of deliberate focus that it's going to take, and you have to have buy-in from across the organization because this type of initiative is not just one organization, success or failure.

We have an organization now we're helping to lead and accelerate. They say it takes a village. So, number one, just acknowledge how it is and make sure that you have the buy-in to do it. Second, all of our members are so unique. They all have different needs. A Medicare member is so different from a 28-year-old individual member who is healthy out on the exchange

and trying to just find a basic insurance product. Understanding the needs of our members is so important. Personalizing that experience for those members is also so important.

As is understanding intent. We're spending a lot of time trying to understand intent, talking about how complex it is to navigate the system. What if we understood intent for every interaction and member, whether it's on the mobile app, whether it's picking up the phone and calling customer service. What if we could understand it through data, through AI? What if we had a really good idea as to why someone was calling. We could serve that member or that provider so much better if we had intent-driven data around that interaction.

I'll give you a great example because so often we're focused on cost takeout. We've got to reduce phone calls because every phone call costs us X number of dollars. Let's implement a whole bunch of technology. Let's put a box in place and let's reduce the phone calls. Well, guess what? If Renee was just diagnosed with cancer, and I need to call in to get some information, I don't want to talk to a bot. I don't want to hear a bot picking up the phone. I want that experience to be that we just got a claim in from Renee. We know she was just diagnosed with cancer. The next call that comes in, we're going to get her to the best darn care agents that can help her. And not send her to the bot, just because it's a more inexpensive path for the transaction.

Moving away from that transaction, I've already talked about the voice of the customer. We use data and analytics and insights to find it. You can have as much data in the world, but you need to understand the insights into that data to help drive decisions. And then lastly, I'm going to end on trust.

I think trust is something that we're just starting to hear more about in the industry. We have thought about trust. Right now, our members have a trusted partnership with their providers, but not with their healthcare company. And we need to build that triangle between the member, the provider and us as their healthcare company. We've got to do better. And I think when we do that, everything becomes a little bit easier.

JP Stephan: Those are great insights, Renee. Shawn, what have you seen as successful that you can share with a group regarding making a change.

Shawn Wagner: Sure. But first, kudos to Renee for pulling off what she's pulling off in such a well-established organization. Kudos to you for all that you're doing, Renee. Our challenge was different. We started from a whiteboard, so our challenge was collecting funds to support the things we wanted to do off the whiteboard. And going back to this building off the product, from a consumer perspective, no consumer is going to say, give me more deductible. No consumer is going to say give me more co-insurance; no consumers want to say limit my choices from the network.

So, we have a broad network with just prices and copays. And, the first experiment we ran was if you give people a product they can understand, they'll make good choices.

We're taking advantage of two superpowers of Americans, which are, they can use Google search and they can use Amazon, Target, or whatever other shopping site. So, if you were able to create that for healthcare, what would happen? We did that, and we tried it and we put out a product that allowed people to pull their phones out. They can pull up a search box, they can type what they're dealing with, and then we can give them options to consider. And it goes along with trust. Renee, I'm glad you mentioned that, which is how far can we take this? The first trust-building exercise was if we can just give them certainty and answer questions about coverage so we can have a definitive yes or no on everything they ask us. Is this covered? Yes or no? We tell them yes or no. That was one. The second thing was, okay, now that you've told me if it's covered, what might I consider doing for what I am dealing with. And then third, how much will those options cost me? Because that's really what I care about—how much it's going to cost me. So, we put that out there to see what happened.

Again, we now have a benefit where people can pick up their phone, they can search like Google and they can get results like Amazon, and then they can make choices. And just something as simple as I'm dealing with a headache or I'm dealing with sinus infection or earache. Typing those types of things into a search box, and then our results set shows you can go to the emergency department that will cost you $500. Or, you can stay in your own house, talk to a doctor virtually, and pay $5. It's up to you, but I'm clear with you on your options.

And what do we see happen? We see that the use of emergency department services on Bind's membership base is 30% to 40% less than benchmark. We see the use of virtual care on the vine benefit is three and a half to four times benchmark. So just making this easy for someone to interact with can make a big difference.

If you give them useful information, they'll take advantage of it and make good choices. I gave you a simple example, but it's the same thing for more complex things. I have knee pain; I have back pain. You can go see an orthopedic specialist, if you want. It will cost you $50 for people we see with great results. It'll cost you $90 for those where we see having more rework on hospital-acquired infections. Or you could get physical therapy for $5. Again, what do we see in our Bind plan? We see the use of elective procedures drop 35% to 40%.

And we see the use of physical therapy jumped 70% to 80%. So again, it goes back to what was our bet. We bet that if you give people a product they could understand and information in a medium they like, their cell phone, they will make better decisions. And lo and behold, what Bind has seen over and

over again is that better decisions are made and it drives tremendous satisfaction.

So, we do a product-market fit test where we ask people if Bind went away, how disappointed would you be? "Not" or "very," and over 80% of people said they'd be disappointed if Bind went away. So, they're happy with the product. And then from a financial perspective, the average out-of-pocket spend for someone on an employer-sponsored plan is over a thousand bucks on average. At Bind it's under $500. So, they like the plan. It's helpful and financially it benefits me as well. And we save our clients upwards of 15% to 20% on their overall spend. And it just comes down to people making better decisions that benefit everybody. So, it works.

JP Stephan: Very tangible examples. Thank you, Shawn. Well, I know we have quite a few questions in the Q&A. Before we transition to some of your questions, we've talked a lot about the problem in terms of product, business model, legacy systems, the solutions of simplified products. Renee, you mentioned this transition from being transactional to being experience-based with an emphasis on understanding intent, as well as the operating model change that's required. What lies ahead?

Renee Ghent: Here's what I would say. Shawn mentioned this earlier. We're ripe for opportunity. I don't think there's a more opportune or exciting time to be in healthcare and technology. But it's going to take a collective industry priority for us to get to where we need to be. We are going to need our large payer systems. We're going to need our large provider systems. We're going to need companies like Shawn's. We're going to need technology. It all needs to come together in a single mission. And I think all of us should be focused on the mission to improve the health of the population.

We need to guide our members. We need to anticipate how do we leverage technology, AI, for example, and to anticipate the intent I spoke about earlier. And remember everybody's healthcare journey is personal. How do we ensure that we're supporting them on their personalized journey to good health? And then we've got to break down the complexities. We've got to simplify it and we feel if we can close those gaps it will lead to trust and we'll make some really good progress, but it is going to take the industry working together to get there.

JP Stephan: Thank you, Renee. Very compelling perspective. We have quite a few questions. I love the level of engagement. We'll try to get to as many of them as we can. There is one in here, "Extremely interesting findings. Thank you. Did you stratify your research by managed care products?" Julian, I'll turn that question over to you.

Julian Feeley: Great question. We broke out the data and what we saw was that the highest proportion of consumers with low health system literacy. When you look at the biggest

differences between those with low system literacy and high system literacy, it's in the individual market. And with Medicaid, there's a higher proportion falling in the low healthcare system literacy side of things.

JP Stephan: Thanks, Julian. What about another related question around was there a control for college or higher education or career? How do we think about education level as it relates to literacy?

Julian Feeley: Another good question. It is something we looked at in the research. So, when we looked at the data it became really clear that traditional education is not what's driving healthcare system literacy. Ninety-eight percent of those with low system literacy have at least a high school degree, over 60% have either graduated college or graduate school. So, it's not about traditional education or trying to teach people to better navigate the system. It's this separate entrenched issue of complexity, making it difficult to navigate healthcare pretty much, no matter who you are.

JP Stephan: Right. Thank you, Julian. And it looks like we're, we're bumping up on time. A very engaging discussion. Thank you to all our panelists. There were some questions about the research being made accessible online. We will work with AHIP to make sure these slides are accessible. There is literature on Accenture's website on this research, where you can dive deeper. Monica, I'll turn it back over to you.

Monica: Thank you so much. Thank you all for your great presentations and for sharing your thoughts. And we thank you to the audience for participating in today's webinar. This concludes today's presentation. Thank you again and enjoy the rest of your day.