

Included Health provider referrals

How high-quality providers drove persistent reductions in total healthcare spend for members with employer-sponsored insurance, 2016–2020

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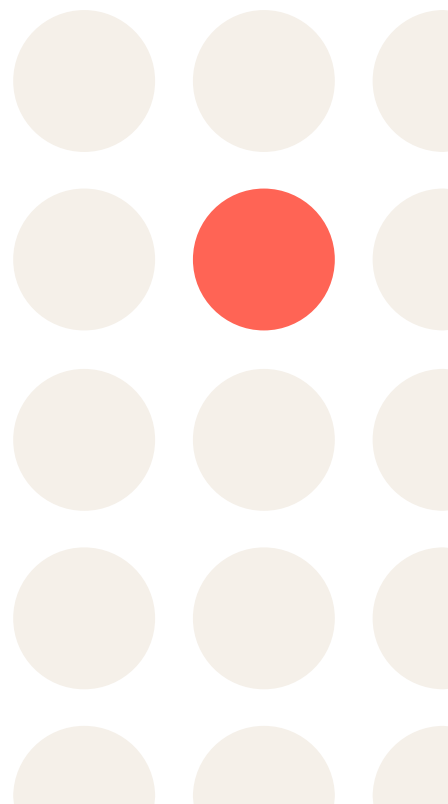
About Included Health

Included Health is a first of its kind integrated virtual care company driven to raise the standard of healthcare for everyone. Our personalized, longitudinal care services include primary care, specialty care, integrated behavioral health, everyday and urgent care, chronic condition management and prevention, and 24/7 triage. We get members to the right care, at the right time through ongoing clinical navigation, expert medical opinions, and care coordination.

Partnering with leading employers and health plans, we deliver unparalleled, end-to-end care. Our combined nationwide practice of dedicated clinicians and innovative data science and technology platforms provide better care experiences, better member satisfaction, and better outcomes and cost savings for our nearly 100 million covered lives across commercial, Medicare, and Medicaid.

Headquartered in San Francisco, the company has been recognized several times in the past year—including Best Workplaces by Inc. magazine, Best Workplaces in Healthcare and Biopharma™ by Great Place to Work and Fortune, Best Overall Digital Health Company by MedTech Breakthrough Awards, and Best Employer Wellness Company by UCSF Digital Health Awards. Learn more at www.includedhealth.com.

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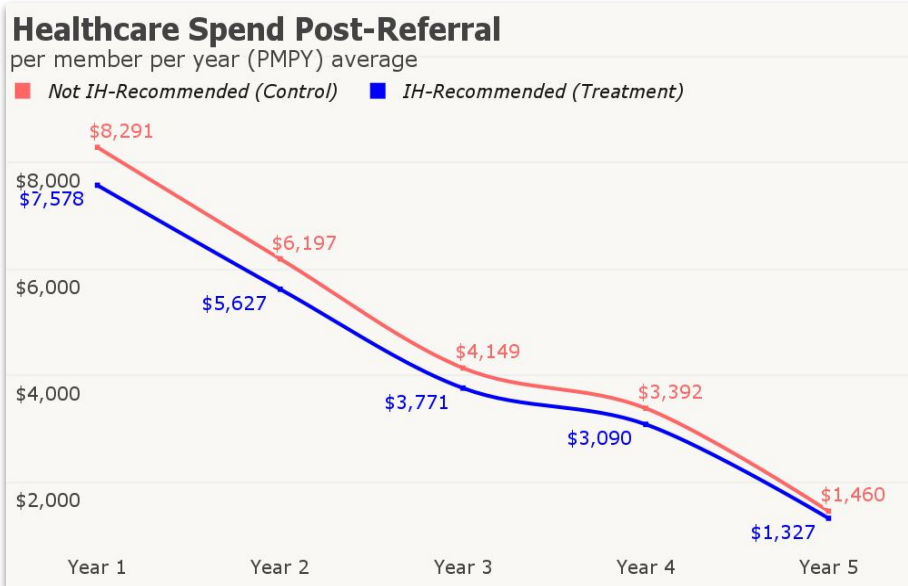


Executive summary

Included Health is on a mission to raise the standard of healthcare for everyone, and we're driving better health outcomes and cost savings for both members and employers. In order to quantify the savings produced by our high-quality provider referrals, we performed a longitudinal, risk-adjusted cohort study on the commercially-insured populations in our book of business.

The study covered over 76,000 members who contacted Included Health for help finding a new provider ("provider referral"). Healthcare costs were compared across two cohorts: (1) members who subsequently visited an Included Health-recommended provider, known as the "treatment group", and (2) members who visited a provider other than those recommended by Included Health, known as the "control group".

The study results indicate that healthcare spend for members who choose Included Health-recommended providers is approximately 9% lower than total spend for similar members who receive care elsewhere. The effect of high-quality referrals is evident in the first twelve months after seeing a new provider, and persists for years afterwards.



Key findings

1 Receiving care from a high-quality provider recommended by Included Health can quickly lead to reductions in total healthcare spend. The difference in cost between the treatment and cohort groups is 8.6% (\$712) in the first twelve months post-referral. Across the five-year study period, Included Health provider referrals led to total savings of 8.9% (\$2,094).

2 Adherence to Included Health provider recommendations can generate savings that persist for several years. For each of the five years in the observation period, members who followed Included Health recommendations experienced up to 9% lower annual healthcare spend.

Background

Included Health was founded on the belief that the best health outcomes should be accessible to everyone. To that end, we have created industry-leading products and services that make it easy for members to find and benefit from top-quality care. Employers partner with us because of our cutting edge approach to quality measurement, clinical expertise, complete care experience, and continuous innovation. These ingredients serve as the key to a new kind of personalized healthcare experience that costs less and keeps people healthier, happier and more productive. We now cover almost 100 million members across 270+ organizations, driving better outcomes, less waste, happier lives, and more time back to employers' HR teams.

Higher quality care leads to better health outcomes and lower costs.

Annually almost \$1 trillion, or one quarter of annual US healthcare spend, is considered waste. Included Health believes that routing to higher quality providers is a practical approach to address this systemic problem. With proper tools, members would connect with high-quality providers much more often. But for most, the selection process is left to chance and it allows low-quality and dangerous doctors to put patients at risk. We believe that the patient-provider match is foundational to better healthcare.

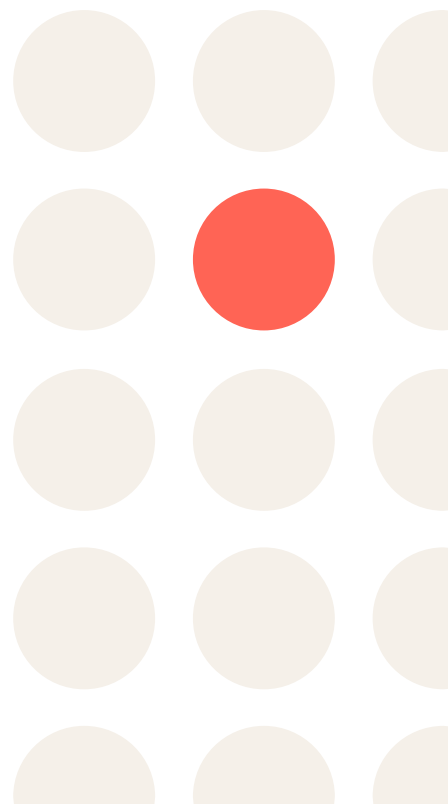
Approach to quality

In 2014, we set out to measure quality at the individual provider level, and have invested over \$75 million in data and talent to build a best-in-class provider quality measurement system. We measure providers on hundreds of specialty-specific metrics across key dimensions of quality: safety, effectiveness, efficiency, and price.

Our provider quality engine powers recommendations for members seeking new provider referrals, who can receive live concierge support from an Included Health Care Coordinator or use self-service products on the web or web portal or mobile app.

Our quality models harness multiple and vast data sources, including commercial claims data sets and proprietary data that we generate through our products and services, to power 100+ unique models, measuring quality for every specialty and over 96% of U.S. providers. We apply the latest machine learning techniques to continue to set the standard for healthcare quality measurement and prediction.

We now cover almost 100 million members across 270+ organizations, driving better outcomes, less waste, happier lives, and more time back to employers' HR teams.



Our provider quality engine is the foundation of the savings we deliver for members and employers. Our models identify individual physicians who are:

Safe. Physicians in the top decile of quality are...

- 64% less likely to prescribe high-dose opioids, and
- 90% less likely to receive a board sanction in the future

... than those in the bottom decile of quality.

Effective. Members visiting the highest-quality physicians experience...

- 18% higher adherence to statin medications,
- 22% higher rates of breast cancer screening,
- 33% lower rates of repeat spine surgeries, and
- 38% lower rates of repeat knee replacements

... compared to members visiting the lowest-quality providers.

Efficient. Physicians in the top quality decile are...

- 44% less likely to conduct unnecessary cervical cancer screenings,
- 19% less likely to prescribe antibiotics inappropriately, and
- 12% less likely to receive inappropriate spine imaging

... than those in the lowest quality decile.

Choosing a higher-quality physician improves outcomes for members and saves money for the member and employer alike, helping to raise the standard of healthcare for everyone.

This report examines the study cohorts, drills down to healthcare savings methodology and results of a study that calculated these savings using historical data.

Physicians in the top decile of quality are

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less likely to prescribe high-dose opioids

Members visiting physicians in the top decile of quality experience

33%

lower rates of repeat spine surgeries

Physicians in the top decile of quality are

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Members visiting physicians in the top decile of quality experience

38%

lower rates of repeat knee replacements

Methodology

This study compared the claims activity of two cohorts of members, namely a treatment cohort and a control cohort, all of whom received a provider referral from Included Health between January 2016 and December 2020. In this case, “received a provider referral” means that the member contacted Included Health for help finding a new provider, and was provided with a recommendation by our care team.

We grouped members into condition categories based on the member’s primary diagnosis code present on the initial provider encounter subsequent to the referral, and compared costs across members within each condition category.

Data sources

- Included Health utilization data for the provider referral service
- Eligibility files received from employers
- Medical claims files received from employers
- Pharmacy claims files received from employers

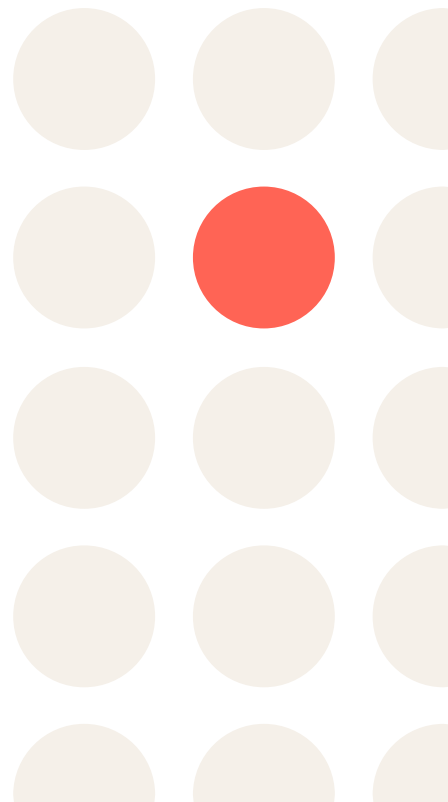
Study cohorts

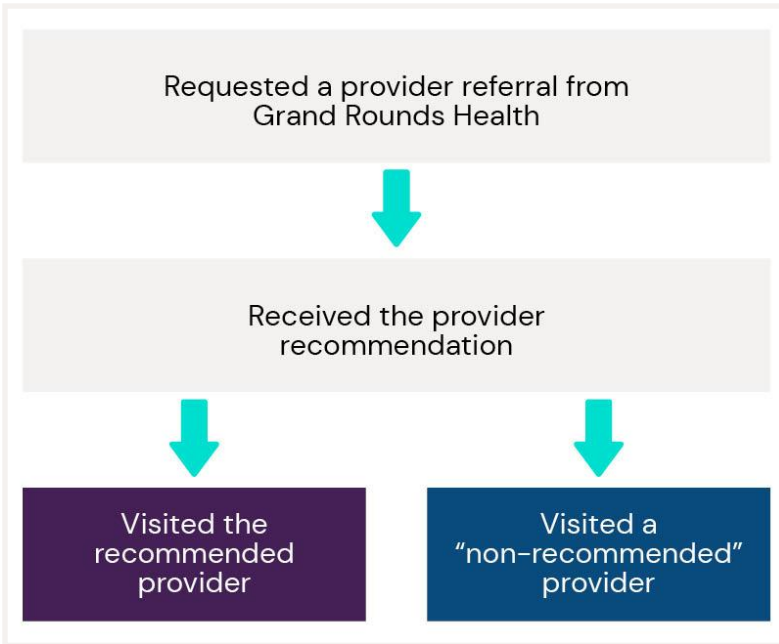
We compared the medical and pharmaceutical claims costs across two cohorts.

1. The **treatment cohort** comprised members who sought a provider referral through Included Health, and visited the provider recommended by Included Health, within 270 days of the referral for PCPs and within 180 days for specialists.
2. The **control cohort** comprised members who sought a provider referral through Included Health, but visited a *different* (“non-recommended”) provider, within 270 days of the referral for PCPs and within 180 days for specialists.

For **both cohorts**, members were included in the cohort only if it was the first encounter between the provider and the member. This ensures that all referrals included in the study were true new physician-patient relationships, and we excluded any instances where members used a Included Health referral to confirm the quality of an existing provider they had found on their own.

For the **treatment cohort**, providers in the same practice as the recommended provider were also included as valid recommended providers. This accounts for scenarios in which a member adhered to the recommendation but was scheduled with an alternative provider, whether due to lack of availability or other constraints.





As a result, we concluded that we had controlled for reasonable population differences and that cost comparisons between the treatment and control cohorts would be valid.

A more detailed explanation on the inclusion criteria for the two cohorts can be found in “Defining treatment and control cohorts” section.

Our analysis showed that members of the treatment and control cohorts were similar in terms of demographics (sex and age), risk score and incidence of chronic conditions (see table 1). The two cohorts also had similar representation across different geographies (defined by Hospital Referral Regions, or HRRs) and employers. There were no members who appeared in both treatment and control groups. As a result, we concluded that we had controlled for reasonable population differences and that cost comparisons between the treatment and control cohorts would be valid. See additional details in the Risk Adjustment section.

Table 1: Comparison of treatment and control cohort characteristics

	Treatment	Control
Count	46,187	28,645
% Male	43%	44%
Average age	43	43
Mean risk score	1.437	1.361
% with chronic condition*	47%	42%

*Includes all conditions identified by the Chronic Condition Indicator (CCI), a tool developed as part of the Healthcare Cost and Utilization Project (HCUP) and sponsored by the Agency for Healthcare Research and Quality (AHRQ).

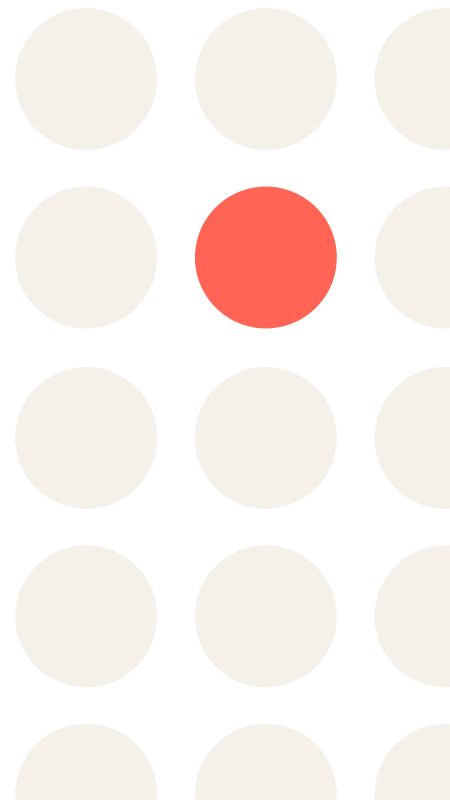


Table 2: Distribution of cases by primary condition category

Condition category*	Condition examples	% of cases
General Health**	Medical exams; preventive care; pain or fever	27.1%
Musculoskeletal	Osteoarthritis; rheumatoid arthritis	11.9%
Circulatory	CHF; hypertension; valve disorders	7.6%
Endocrine & Metabolic	Diabetes; obesity	7.3%
Nervous System	MS; eye disorders; migraine	6.0%
Infectious & Parasitic Diseases	TB; hepatitis; HIV	5.5%
Genitourinary	Chronic kidney disease; endometriosis	5.4%
Respiratory	Asthma; COPD	5.3%
Skin & Subcutaneous Tissue	Fungal infection; abscess	5.1%
Mental & Behavioral Disorders	Anxiety; depression	4.0%
Digestive	Liver disease; acid reflux; ulcer	3.6%
Neoplasms	Breast cancer; melanoma	3.2%
Ill-Defined Symptoms	Abnormal lab results; sleep apnea	2.8%
Pregnancy	Gestational diabetes; ectopic pregnancy	2.5%
Injury & Poisoning	Muscle strain	2.4%
Blood Diseases	Anemia; white blood cell diseases	0.5%
Congenital Malformations	Musculoskeletal deformities	0.2%

* Reflects the condition category of the primary diagnosis coded on the initial encounter between the member and the provider. Condition categories are defined using Clinical Classifications Software Refined (CCSR), which aggregates ICD-10 diagnoses into clinically meaningful categories organized across 21 body systems.

** General Health includes primary diagnoses within the category, Symptoms; signs; and ill-defined conditions and factors influencing health status.

Study exclusions

Members whose total healthcare spending exceeded \$100,000 in any month or \$250,000 in any year were excluded. These outliers represent 3.4% of total cases. Members were also excluded if they were not eligible for coverage at the time of the provider referral, at the time of the subsequent encounter, or for a minimum of 6 months following the referral.

Members whose total healthcare spending exceeded \$100,000 in any month or \$250,000 in any year were excluded.

Study period

For each member included in the study, the date of the provider referral is designated as the "index event". A concierge provider referral service is considered completed when the care team member selects a "recommended provider" for the member and the member receives that recommendation. A self-service provider referral is considered completed when the member receives the recommendations via the online platform.

The study examined cost differences between the treatment and control cohorts across five one-year periods, with each year subsequent to the index event denoted "post-Included Health year 1", "post-Included Health year 2", and so on.

Calculation

Projection of costs

Aggregate medical and pharmacy allowed amounts ("healthcare spend") were calculated from adjudicated claims for each cohort member for each of the 24 months in the study period. Both member- and plan-paid costs were included. We analyzed new provider encounters in the customer claims data from 2016 to 2020 to determine the change in total healthcare cost after a new PCP or specialist visit and used this data to calculate annual rates of change for years 3, 4, and 5, simulating the change in cost for both the control and treatment groups.

Risk adjustment

In order to allow for cost comparisons between treatment and control groups, we calculated a risk score for every member included in the analysis using the Hierarchical Condition Categories (HCC) methodology, created by the Department of Health and Human Services. In addition to demographic risk factors such as age and gender, the HHS-HCC methodology uses medical and pharmaceutical claims data to algorithmically produce a risk adjustment factor, accounting for interactions between multiple conditions. These risk scores are weighted according to the predicted impact on total healthcare spend. A risk score of "1.0" reflects a member with an expected healthcare spend typical of a commercially-insured population.

An illustrative risk score calculation is shown below:

A risk score of "1.0" reflects a member with an expected healthcare spend typical of a commercially-insured population.



Anna's risk score for 2020			
Type	Details	Risk score contribution	Overall risk score
Demographics	Female, 40-44 years old	0.42	3.6
Dx	Specified heart arrhythmias	2.314	
Dx	Asthma	0.719	
Rx	Antiarrhythmics	0.118	

After calculating each member’s risk score, we computed **risk adjustment factors** for each cohort at the time of the referral (the “index event”) and adjusted the spend for each period to reflect the control group’s risk profile. A sample risk adjustment calculation is shown below:

Example: Risk-adjusted spend calculation

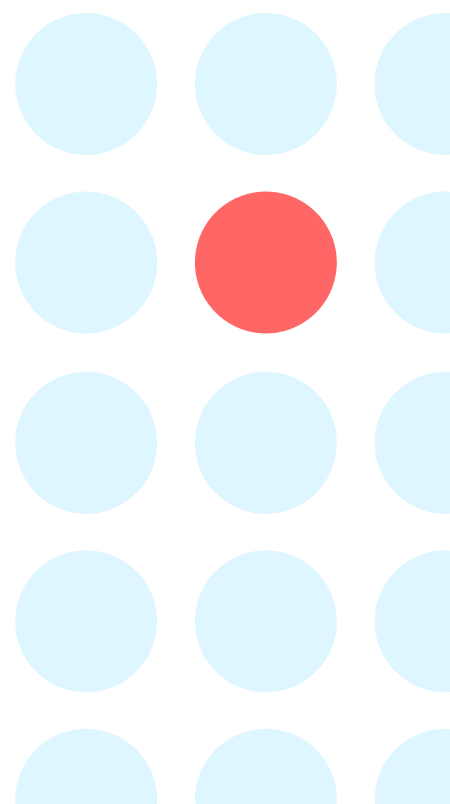
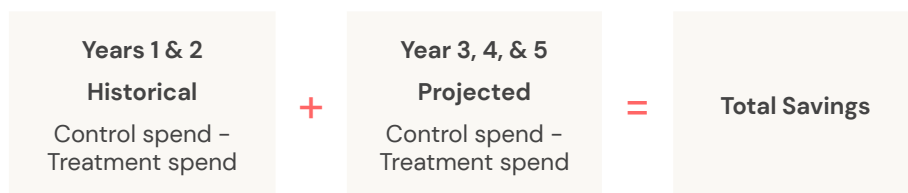


Savings calculation

After having adjusted the control group’s spend in each period to the risk profile of the treatment group and projecting year 2 costs to years 3, 4, and 5, we arrive at final savings amounts for each period by summing the cost difference in each of the five years.

Savings is calculated for each of the condition categories observed in the primary diagnosis of the first encounter between the member and the provider. Then, the distribution of provider referrals across all condition categories is applied to determine the member-weighted average savings.

Example: Savings calculation for five years after referral



Results

Members who visited Included Health–recommended providers experienced \$2,094 lower spend in the 5–year period following the initial encounter, as seen in Table 3.

Savings by condition category

Savings were observed across condition categories represented in the primary diagnosis of the member by the provider. In Table 3, condition categories comprising less than 5.5% of total cases are included within the category “All other”.

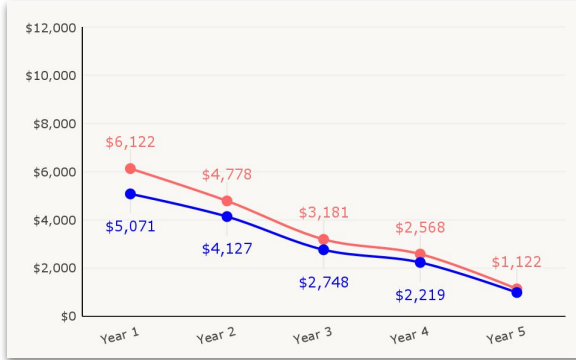
Table 3: Total risk–adjusted healthcare spend and savings for members seeing Included Health–recommended providers

Condition Category	% of Cases	Total 5–year Savings
General Health	27.1%	\$2,636
Musculoskeletal	11.9%	\$3,482
Circulatory	7.6%	\$1,254
Endocrine & Metabolic	7.3%	\$6,445
Nervous	6.0%	\$1,005
Infectious & Parasitic	5.5%	\$3,148
All Other	34.5%	\$465
Overall	100.0%	\$2,094

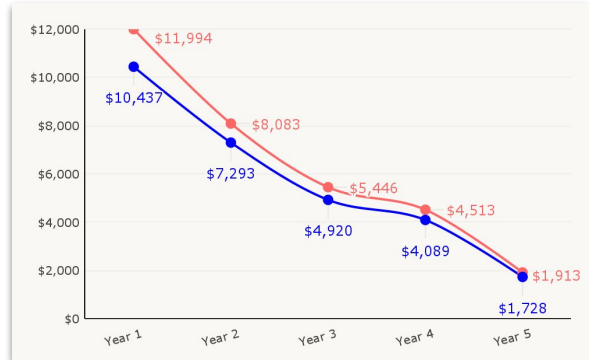
* Note: Row and column sums may differ due to rounding

Total risk-adjusted healthcare spend for members seeing Included Health-recommended providers

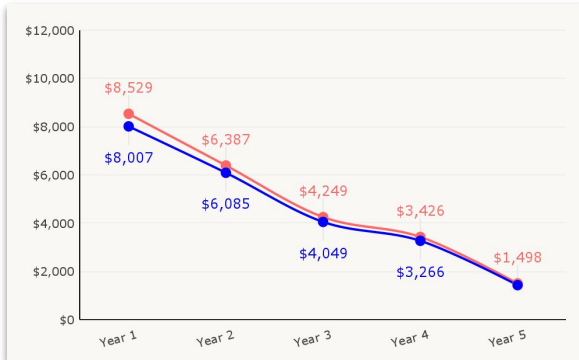
General health
\$2,636 savings



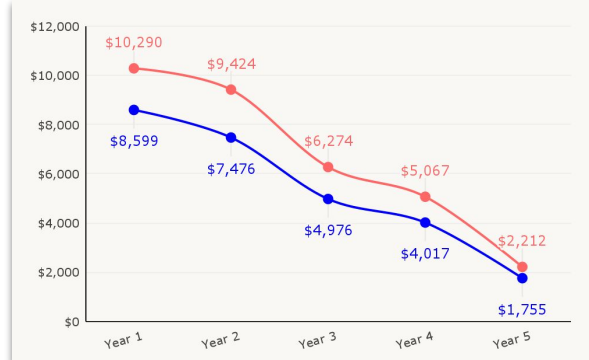
Musculoskeletal & nervous system
\$3,482 savings



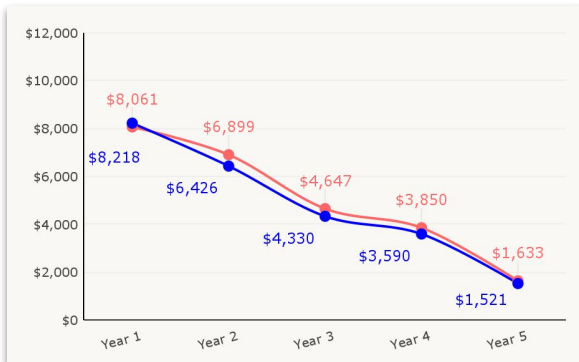
Circulatory
\$1,254 savings



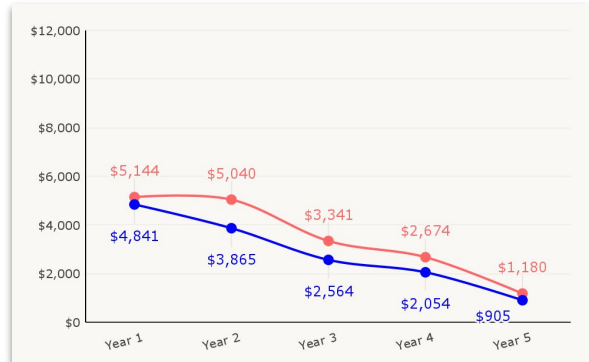
Endocrine & metabolic
\$6,455 savings



Nervous
\$1,005 savings



Infectious & parasitic diseases
\$3,148 savings



Discussion

Sources of savings

We observed that members who visited Included Health–recommended physicians had fewer downstream costs billed from inpatient and outpatient hospitals, emergency rooms, and offices.

Table 4: Cost and utilization changes across sites of service, from pre-IH to post-IH year 1

Site of Service	Difference in Spend (pre-IH vs. post-IH year 1, Treatment vs. Control)	
	Cost (\$ PMPY)	Utilization (% of members)
Outpatient Hospital	-\$301	-3.9%
Inpatient Hospital	-\$230	-3.2%
Emergency Room	-\$116	-2.6%
Office	-\$71	-2.1%
Ambulatory Surgical Center	\$1	-1.3%
Independent Laboratory	\$5	-4.3%

Members visiting Grand Rounds Health–recommended providers had lower costs and utilization across places of service – particularly hospitals and emergency rooms.

We also observed differences in the changes in pharmaceutical costs across the treatment and control groups. Specifically, members who visited Included Health–recommended providers had lower costs across all drug types, including both branded and generic drugs, compared to the control group. They also had higher utilization rates of generic drugs, yet still generated lower overall generic drug costs.

Table 5: Differences in changes in cost and utilization for pharmaceutical drug types, from pre-IH to post-IH year 1

Drug Type	Difference in Spend (pre-IH vs. post-IH year 1, Treatment vs. Control)	
	Cost (\$ PMPY)	Utilization (% of members)
Branded <i>(incl. Single-Source Brand, Multi-Source Brand, Branded Generics)</i>	-\$66	-4.7%
Generic <i>(incl. Generics and Original with Generics)</i>	-\$43	1.8%
Not Specified <i>(incl. OTC Drugs and Not Specified)</i>	-\$52	0.1%

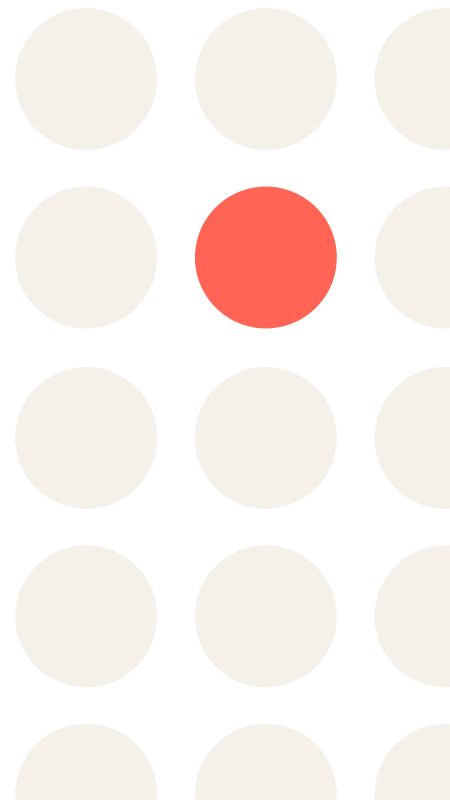
Members visiting Grand Rounds Health-recommended PCPs had lower costs from both branded and generic drugs.

Distribution of savings over time

The study of actual savings was performed over a two-year period, allowing us to observe differences in the magnitude of savings by time period. Overall, savings were higher in the first year than in the second year after the initial provider referral (\$1,293 vs. \$1,002 respectively). This suggests that Included Health-recommended providers drive most savings in the immediate term. While additional actual savings analysis extending the post-referral window beyond two years is forthcoming, we studied the limited cases with three to five years of claims data to ascertain overall cost changes that could be applied proportionately to the existing two-year savings.

When we look at specific condition categories, there is some variation in the magnitude of savings by year. To give two examples:

- For **Musculoskeletal** referrals, savings were higher in the first year than they were in the second year (\$2,169 vs. \$1,389 respectively). This is likely due to the avoidance of high-cost surgeries or other invasive treatments, by recommending physicians who favor more conservative, restorative treatments for musculoskeletal conditions.
- On the other hand, for **Endocrine & Metabolic** referrals, savings were higher in the second year than they were in the first year (\$2,115 vs. \$853 respectively). This is likely due to the avoidance of downstream complications from diabetes, such as hospitalizations and ER visits, by recommending physicians who can help their patients more effectively manage diabetes, and adhere to treatment.



Defining treatment & control cohorts

The control cohort was designed to isolate the effect of Included Health provider recommendations, and to remove potential confounding factors, including:

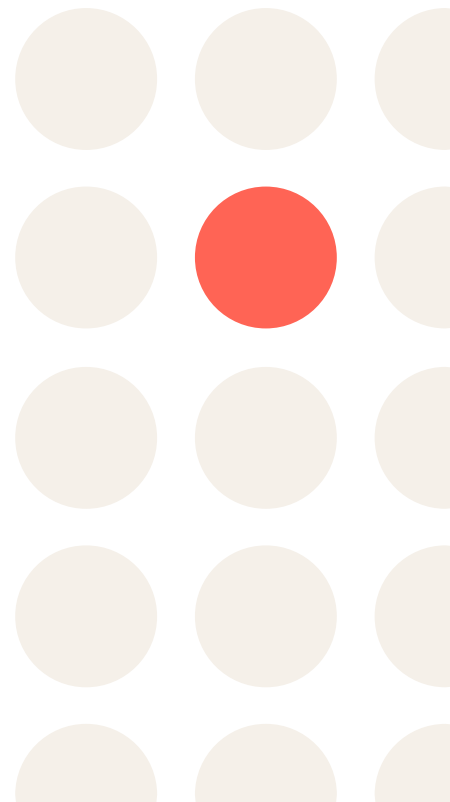
- The possibility that members seeking a provider referral are more motivated and engaged in their healthcare.
- The risk profile for members who sought a provider referral through Included Health (members included in the study had average risk scores of up to 1.84 vs. the average risk score of 1.00 across commercially-insured populations).

Other criteria for the control cohorts were considered and rejected for various reasons. These other potential control cohorts include:

- **Members who did not complete a provider referral through Included Health, but who sought a new provider on their own.**

We did not use this as our control cohort for several reasons:

- Firstly, comparing “users” with “non-users” may introduce bias into the study. Members who engage with third-party benefits, rather than using traditional channels for getting care, may be more engaged with their own healthcare. This may have resulted in savings that were unreliable and/or inflated due to differences in population characteristics.
 - Secondly, with this “non-user” group, it would have been difficult to identify a “new” provider in claims data. “New office visit” procedure codes would have provided some direction, but use of these codes in claims is inconsistent across individual providers and provider types (Specialists are far less likely to use these codes, compared to PCPs). Since the control cohort initiated a provider referral, we know their intent to find a new provider, and don’t have to infer it based on incomplete data.
- **Members who did not see any provider at all after initiating a provider referral.** Clinical profiles of members who choose to not seek care at all tend to be very different than those who do seek care, and these differences would have been difficult to control for. Also, some cases may have been started inadvertently, or on behalf of other family members.



Areas for further study

Future analysis should consider:

- **Projected versus actual costs in years three through five.** Actual post-referral costs should be used in lieu of projected costs whenever appropriate. As more data accrues, we will be able to extend the period for using actual costs for converted cases rather than using projected claim costs.
- **Savings by service type.** Future iterations of the savings methodology may separate values for savings generated by converted cases across the Provider Match and Concierge Referral service types.

Calculating cost savings for provider referrals

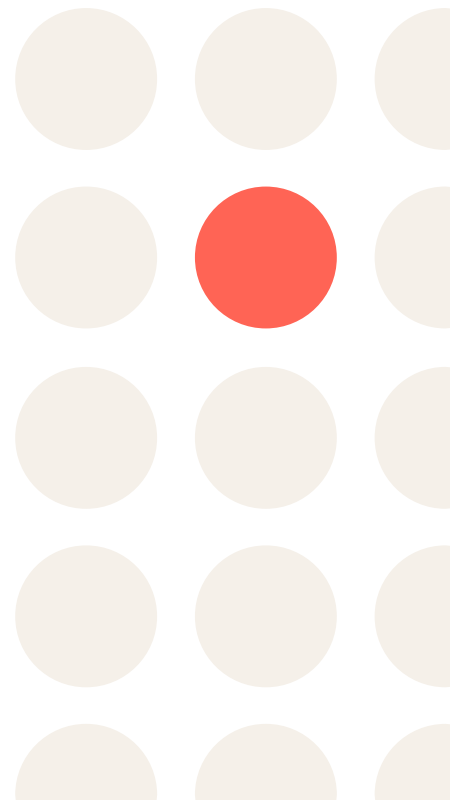
This savings methodology is based on the study discussed above, which found that Included Health-recommended providers delivered significant cost savings during the five-year period following the initial referral. In this calculation, a “converted referral” means that the member received a referral to a recommended provider who later provided medical services as documented in claims data. Accounting for the rate of conversions ensures that savings are only claimed when a referral results in a visit to a provider.

$$\begin{array}{|c|} \hline \text{Total Savings from} \\ \text{Provider Referrals} \\ \hline \end{array} = \begin{array}{|c|} \hline \text{\# of Converted} \\ \text{Referrals} \\ \hline \end{array} \times \begin{array}{|c|} \hline \text{Avg. Savings per} \\ \text{Converted Referral} \\ \hline \end{array}$$

Notes:

Unique converted referrals refers to the number of members who received a Included Health provider referral, and actually visited the recommended provider within a certain timeframe, as observed in their medical claims data (270 days for primary care searches and 180 days for specialist searches).

Providers of the same specialty in the same practice as the recommended provider are also included as valid recommended providers. This accounts for scenarios in which a member followed the recommendation but was scheduled with an alternative provider due to lack of availability or other constraints.



Claims data are used to calculate the number of converted referrals, using primary diagnosis code on the first claim after the recommendation to attribute provider referrals to member condition categories.

Detailed Steps:

	Step	Example: Acme Corp																																				
1	Find the number of unique converted referrals .	In Q1 2021, Acme members received 1,000 unique referrals, of which 200 converted.																																				
2	Attribute the converted referrals to condition categories by identifying the member’s primary diagnosis on the initial visit with the recommended provider.	<p>The 200 unique converted referrals fell under the following condition categories:</p> <table border="1"> <thead> <tr> <th>Condition Category</th> <th># of Referrals</th> </tr> </thead> <tbody> <tr> <td>General Health</td> <td>50</td> </tr> <tr> <td>Musculoskeletal</td> <td>20</td> </tr> <tr> <td>Circulatory</td> <td>20</td> </tr> <tr> <td>Endocrine & Metabolic</td> <td>20</td> </tr> <tr> <td>Nervous</td> <td>10</td> </tr> <tr> <td>Infectious & Parasitic</td> <td>10</td> </tr> <tr> <td>All Other</td> <td>70</td> </tr> </tbody> </table>	Condition Category	# of Referrals	General Health	50	Musculoskeletal	20	Circulatory	20	Endocrine & Metabolic	20	Nervous	10	Infectious & Parasitic	10	All Other	70																				
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3	For each condition category, multiply the number of unique converted referrals by savings per case .	<p>Acme’s total savings are calculated in the following table:</p> <table border="1"> <thead> <tr> <th>Condition Category</th> <th># of Referrals</th> <th>Savings / Case</th> <th>Total Savings</th> </tr> </thead> <tbody> <tr> <td>General Health</td> <td>50</td> <td>\$2,636</td> <td>\$132K</td> </tr> <tr> <td>Musculoskeletal</td> <td>20</td> <td>\$3,482</td> <td>\$70K</td> </tr> <tr> <td>Circulatory</td> <td>20</td> <td>\$1,254</td> <td>\$25K</td> </tr> <tr> <td>Endocrine & Metabolic</td> <td>20</td> <td>\$6,445</td> <td>\$129K</td> </tr> <tr> <td>Nervous</td> <td>10</td> <td>\$1,005</td> <td>\$10K</td> </tr> <tr> <td>Infectious & Parasitic</td> <td>10</td> <td>\$3,148</td> <td>\$31K</td> </tr> <tr> <td>All Other</td> <td>70</td> <td>\$465</td> <td>\$33K</td> </tr> <tr> <td>Total</td> <td>200</td> <td>\$2,148</td> <td>\$430K</td> </tr> </tbody> </table>	Condition Category	# of Referrals	Savings / Case	Total Savings	General Health	50	\$2,636	\$132K	Musculoskeletal	20	\$3,482	\$70K	Circulatory	20	\$1,254	\$25K	Endocrine & Metabolic	20	\$6,445	\$129K	Nervous	10	\$1,005	\$10K	Infectious & Parasitic	10	\$3,148	\$31K	All Other	70	\$465	\$33K	Total	200	\$2,148	\$430K
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General Health	50	\$2,636	\$132K																																			
Musculoskeletal	20	\$3,482	\$70K																																			
Circulatory	20	\$1,254	\$25K																																			
Endocrine & Metabolic	20	\$6,445	\$129K																																			
Nervous	10	\$1,005	\$10K																																			
Infectious & Parasitic	10	\$3,148	\$31K																																			
All Other	70	\$465	\$33K																																			
Total	200	\$2,148	\$430K																																			

Standard conversion rates & per-case savings

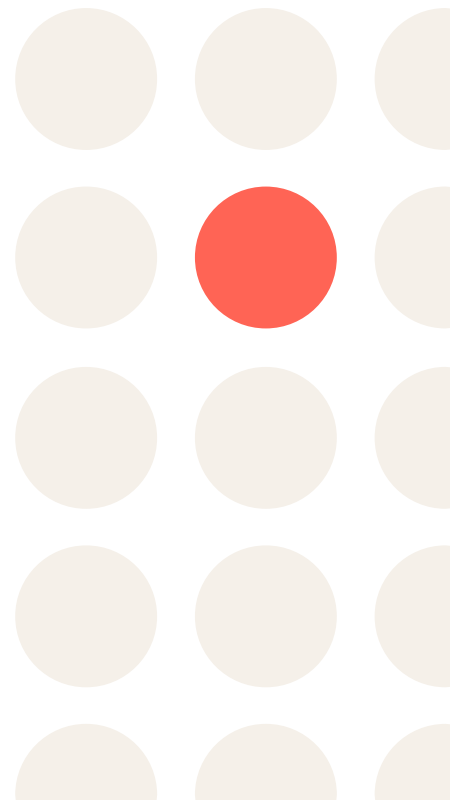
Where Included Health does not receive validated claims data, we proceed as follows:

- **Apply a standard “book-of-business” conversion rate** for provider referrals based on historical data from all Included Health customers.
- **Assume a standard cost savings per referral** based on historical data from all Included Health customers.

Current standard conversion rates and cost savings per referral values are noted below. Separate conversion rates are calculated for high-touch “Concierge Referral” and self-service “Provider Match” cases, according to the distribution of cases across condition categories.

Standard conversion rates are based on historical data provider referrals and represent the proportion of unique members who sought a provider referral and subsequently received medical services from a Included Health-recommended provider.

	Concierge Referral High-touch cases	Provider Match Self-service cases
Standard conversion rate	42%	29%
Standard savings per referral	\$2,094	\$2,094





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