

MILLIMAN REPORT

Medical cost comparison: DispatchHealth access group against a matched market benchmark

Commissioned by DispatchHealth

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Executive summary

Study scope and intended use

DispatchHealth (Dispatch) commissioned Milliman to conduct a study comparing Regence BlueShield (Regence)'s commercial and Medicare Advantage medical claims costs of Regence's members offered Dispatch's services (the "access group") to "market" medical claims costs. This study evaluated claims costs from calendar years (CYs) 2022, 2023, and 2024.

Dispatch is a healthcare company that offers at-home care alternatives to hospitals and emergency rooms. Regence contracted with Dispatch to offer Dispatch's services to its members.

This report describes the results of the study for Regence's costs on a 100% of Medicare-allowed basis for members with access to Dispatch's services compared to a matched market benchmark. Although the study illustrates reductions in cost, this report is not intended to opine on the effectiveness of Regence or Dispatch's services and is not an endorsement of any program. Any reader of this report must possess a certain level of expertise in areas relevant to this analysis to evaluate the applicability of the scope, assumptions, methodology, and results of this report to any other population or timeframe. Milliman recommends that third parties be aided by an actuary or another qualified professional when reviewing this report.

Results

For this analysis, we created a matched population consisting of commercially insured, self-insured, and Medicare Advantage insured individuals in Washington state by conducting propensity score and exact matching to ensure adequate covariate balance between the access group and the matched population. To further control for variation between the populations, we applied regression modeling to the matched dataset; a linear regression output showed how one or more independent variables (predictors) were related to a dependent variable (outcome).

The study revealed statistically significant medical cost savings for both the Commercial group and Medicare Advantage members enrolled in Regence's products with access to Dispatch's services relative to market products.

Total cost savings were calculated using medical per member per month (PMPM) allowed dollars on a 100% of Medicare basis. Access-group savings are shown below as a percentage of the control group's allowed PMPM and actual allowed PMPM dollars. Behavioral health claims and maternity claims were excluded from total medical costs and all supporting figures in this report, as Dispatch's service model does not focus on these categories of care. For both the access and control groups, members exceeding the 99th percentile of Medicare-allowed PMPM cost by year and line of business were excluded from the analysis. The post-regression results shown below are derived by applying a linear regression model to the matched population, which illustrates an estimation of cost savings by adjusting for remaining differences (independent variables) between the access group and the market products. Savings estimates in this report can be interpreted as reflecting differences in the volume and mix of services used by the access group relative to the market, not differences in unit price or contract terms. Results should be interpreted as correlational, reflecting differences between comparable populations at a point in time, rather than as a causal estimate of the effect of an individual member gaining access to Dispatch's services.

- **2022 post-regression cost savings for Regence's access group compared to all market products**
 - Commercial group: 14% of medical-allowed dollars (\$20.93 savings PMPM compared to market)
 - Medicare Advantage: 19% of medical-allowed dollars (\$103.17 savings PMPM compared to market)
- **2023 post-regression cost savings for Regence's access group compared to all market products**
 - Commercial group: 14% of medical-allowed dollars (\$24.40 savings PMPM compared to market)
 - Medicare Advantage: 13% of medical-allowed dollars (\$76.76 savings PMPM compared to market)

- **2024 post-regression cost savings for Regence's access group compared to all market products**
 - Commercial group: 11% of medical-allowed dollars (\$19.59 savings PMPM compared to market)
 - Medicare Advantage: 14% of medical-allowed dollars (\$96.26 savings PMPM compared to market)

All savings estimates shown above are statistically significant ($p\text{-value} \leq 0.05$).

In 2024, savings PMPM in the Commercial line of business were estimated between \$18.28 and \$20.90, the bounds of the 99% confidence interval (CI). In the Medicare Advantage line of business, savings were estimated to be between \$79.62 and \$112.91. All savings estimates were statistically significant at the 99% confidence level, indicating a high degree of certainty that the true cost savings for the access-group members fell within the reported CIs.

Medicare Advantage cost savings were driven largely by reductions in inpatient medical and surgical costs, which were statistically significant across all three studied years, partially offset by higher costs associated with primary care physician (PCP) home visits. Commercial group savings reflected a broader combination of outpatient and professional cost reductions.

Background

Dispatch commissioned Milliman to conduct a study and prepare a report comparing Regence's medical costs for the company's CY 2022 to CY 2024 population with access to Dispatch's services relative to the market. This includes members in the Commercial group and Medicare Advantage lines of business.

Dispatch offers Emergency Room Alternative Care (ERAC), an in-home, mobile care model intended to serve as an alternative to hospital and emergency department (ED) visits for certain acute and urgent conditions. Regence contracts with Dispatch to make these services available to eligible members. We did not evaluate Dispatch's specific claims regarding its care delivery approach; instead, we compared the overall access-group costs relative to a matched market benchmark.

Objective

The goal of this analysis was to compare access-group members to a group of market members who were as similar as possible—in age, gender, geography, health conditions, and other characteristics—so that any difference in cost could be attributed to access to Dispatch's services rather than to other underlying differences between the two populations. To achieve this, we performed exact and propensity-score matching combined with linear regression modeling. These techniques are specifically designed to address confounding factors in observational studies by controlling for a range of member characteristics. This analysis compared claims and membership data associated with members that had access to Dispatch's services against market members from [Milliman's Consolidated Health Cost Guidelines Source Database \(CHSD\)](#). The study was restricted in scope to commercial employer-group fully insured, self-insured, and Medicare Advantage populations in Washington state.

Results

This section presents key findings from the study comparing medical cost outcomes for the access-group population to the matched market benchmark population. We accomplished this using a statistical technique called propensity score matching, which matches each access-group member with one or more market members sharing similar characteristics, followed by a regression model that further adjusts for any remaining differences between the matched groups. Additional detail on this methodology is provided in the *Methods* section.

All medical costs presented in this section reflect Medicare-repriced allowed amounts, rather than actual negotiated allowed, paid, or billed dollar amounts. This approach, and the rationale behind employing it, is described in the *Methods* section under *Cost basis and repricing methodology*.

Covariate balance was carefully assessed prior to estimating outcomes. Following the balance assessment, results from the linear regression model are presented, highlighting the estimated impact of access to Dispatch's services on medical costs. Supplementary analyses by age band and geography are also presented to provide additional context on the drivers and consistency of the core findings.

Matching

Access-group members for this study were restricted to individuals residing in Washington state during their Regence enrollment. Using members' residence, we mapped the sets of membership data from both the access and control groups to metropolitan statistical areas (MSAs). Due to the volume, we consolidated some MSAs into a broader "Other MSA" group prior to matching. Members residing outside Washington state were excluded from the analysis for both Regence and the market. Additional demographic and enrollment characteristics—including age band, line of business, gender, member months, and product—were also incorporated into the matching process to further align the access and control groups.

FIGURE 1: INCLUDED MSAS AND MSA GROUPINGS USED FOR MATCHING

MSA name	MSA used for matching
Seattle–Bellevue–Kent, WA	Seattle–Bellevue–Kent, WA
Tacoma–Lakewood, WA	Tacoma–Lakewood, WA
Everett, WA	Everett, WA
Spokane–Spokane Valley, WA	Spokane–Spokane Valley, WA
Olympia–Lacey–Tumwater, WA	Olympia–Lacey–Tumwater, WA
Bellingham, WA	Other MSA
Mount Vernon–Anacortes, WA	Other MSA
Bremerton–Silverdale–Port Orchard, WA	Other MSA
Portland–Vancouver–Hillsboro, OR-WA	Other MSA
Longview, WA	Other MSA
Wenatchee, WA	Other MSA
Kennewick–Richland, WA	Other MSA
Non-MSA Area, WA	Other MSA
Walla Walla, WA	Other MSA
Lewiston, ID-WA	Other MSA
Yakima, WA	Other MSA

To support matching on members with similar conditions, we developed flags for each member based on the August 2025 revision of the Centers for Medicare and Medicaid Services (CMS) chronic conditions data warehouse¹ (CCW). CCW conditions of cataract, glaucoma, and depressive mood disorders were excluded from the matching criteria since these conditions are out of scope for the core services supplied by Dispatch. Each member was flagged for conditions based on the presence of any valid diagnosis code on any claim for the given year. Some CCW conditions (e.g., cancer types) were grouped together prior to matching based on similarities within each condition. Additionally, to capture members with similar conditions based on costs, we labeled each member's highest Medicare allowed-cost condition for each member year so that an individual with recurring costs for a specific chronic condition could be appropriately matched to a member in the market. We also captured members with the presence of five or more conditions, isolating high-cost members with more than five comorbidities.

FIGURE 2: CCW CONDITIONS INCLUDED AND GROUPINGS USED FOR MATCHING

CCW condition	Condition grouping
Cancer (breast, colorectal, endometrial, lung, prostate, urologic)	Cancer
Acute myocardial infarction, atrial fibrillation and flutter, heart failure and non-ischemic heart disease, ischemic heart disease, stroke/transient ischemic attack	Cardiovascular
Diabetes, hypertension, hyperlipidemia, hypothyroidism	Metabolic
Asthma, chronic obstructive pulmonary disease, pneumonia (all-cause)	Respiratory
Alzheimer's disease, non-Alzheimer's dementia, Parkinson's disease and secondary Parkinsonism	Neurological
Hip/pelvic fracture, osteoporosis (with/without fracture), rheumatoid arthritis/osteoarthritis	Musculoskeletal
Chronic kidney disease	Renal
Anemia, benign prostatic hyperplasia	Other

Indicators were assigned by year for members with urgent care (UC), ED, and PCP home visits to measure the effects associated with Dispatch's services and to accurately capture individuals actively using these sites of care. ED visits were classified as low- or high-acuity based on HCPCS procedure codes. UC and low-acuity ED visits were combined into a single utilization flag, as both represent lower-severity, unscheduled care that Dispatch aims to serve as an alternative to. High-acuity ED visits were classified separately to isolate higher-cost ED encounters each year.

The following variables were used in matching between the access-group (target) and market (control) populations. Because member geographic location can materially affect cost outcomes, we required an exact match on the MSA group. To ensure members were matched on similar clinical needs, we also required exact matches on age band, primary CCW condition, presence of high-acuity ED visits, and year.

FIGURE 3: COVARIATES AND MATCH TYPE (EXACT/PROPENSITY SCORE)

Criteria	Match type
MSA group	Exact
Age band	Exact
Primary CCW condition	Exact
Presence of high-acuity ED visit	Exact
Year	Exact
Line of business	Exact
Gender	Propensity score
Member months	Propensity score
Product	Propensity score
Dependency code	Propensity score
Presence of 5+ comorbidities	Propensity score
Presence of CCW cardiovascular	Propensity score
Presence of CCW metabolic	Propensity score
Presence of CCW respiratory	Propensity score
Presence of CCW neurological	Propensity score
Presence of CCW musculoskeletal	Propensity score
Presence of CCW cancer	Propensity score
Presence of CCW renal	Propensity score
Presence of CCW other	Propensity score
Presence of ED or UC visit	Propensity score

Criteria	Match type
Presence of low-acuity ED visit	Propensity score
Presence of PCP home visit	Propensity score

Assessing covariate balance

To ensure valid comparisons in this study, the control and target groups should be similar with respect to observed characteristics; a concept known as covariate balance. Achieving covariate balance reduces bias and strengthens the validity of causal inferences. Two commonly used methods for assessing balance are standardized mean differences (SMDs) between control and target groups for each matching variable and the examination of propensity score distributions for common support. SMDs provide a quantitative measure of differences in covariate means between groups, with values between -0.1 and 0.1 indicating good balance; values outside this range suggest imbalance³. Additionally, visualizing the overlap of propensity score distributions before and after matching helps evaluate how well the matching process has created comparable groups.

FIGURE 4: SMDs OF COVARIATES BEFORE AND AFTER MATCHING



As shown in Figure 4, all covariates had SMDs between -0.1 and 0.1 , indicating satisfactory control of potential confounders and minimal systematic differences between the groups. This included the SMD for propensity score, labeled as “distance” in Figure 4, which reflects the difference in estimated propensity scores between matched treatment and control units.

Regression output

A linear regression was performed on the matched dataset to estimate the medical cost differences for those with access-group membership, controlling for the covariates listed in Figure 3. Negative values indicate cost savings for the access group relative to the matched market benchmark; positive values indicate higher costs for the access group. Results are presented both for the full access-group population and, supplementarily, for the subset of access-group members who had a Dispatch visit, identified via National Provider Identifier (NPI). Only the Commercial group and Medicare Advantage lines of business are presented; see *Methods: Exclusions*.

Medical total

FIGURE 5: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL (ACCESS GROUP)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Commercial	-\$20.93	0.00	-14.4%
2023	Commercial	-\$24.40	0.00	-14.1%
2024	Commercial	-\$19.59	0.00	-10.8%
2022	Medicare Advantage	-\$103.17	0.00	-19.1%
2023	Medicare Advantage	-\$76.76	0.00	-12.6%
2024	Medicare Advantage	-\$96.26	0.00	-13.7%

Total medical results demonstrated statistically significant post-regression cost savings for the access group across both Commercial and Medicare Advantage lines of business, in every study year.

Inpatient – Medical and surgical

FIGURE 6: POST-REGRESSION COST COMPARISON – INPATIENT MEDICAL & SURGICAL (ACCESS GROUP)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Commercial	-\$2.55	0.00	-37.2%
2023	Commercial	-\$3.32	0.00	-38.8%
2024	Commercial	-\$2.94	0.00	-33.1%
2022	Medicare Advantage	-\$50.11	0.00	-45.1%
2023	Medicare Advantage	-\$50.90	0.00	-41.3%
2024	Medicare Advantage	-\$57.98	0.00	-38.2%

Inpatient medical and surgical costs showed large, statistically significant percentage reductions for the access group in both lines of business across all study years. For Medicare Advantage, dollar-level reductions were approximately \$50 to \$58 PMPM and were a primary driver of the Medicare Advantage total medical savings shown in Figure 5.

Emergency department – Total

FIGURE 7: POST-REGRESSION COST COMPARISON – ED TOTAL (ACCESS GROUP)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Commercial	+\$0.21	0.01	+2.6%
2023	Commercial	+\$0.60	0.00	+6.3%
2024	Commercial	+\$1.01	0.00	+9.6%
2022	Medicare Advantage	–\$1.22	0.00	–8.7%
2023	Medicare Advantage	–\$1.93	0.00	–10.1%
2024	Medicare Advantage	–\$0.50	0.35	–2.2%

Across the Commercial line of business, the dollar-level impact of access-group membership on ED total costs ranged from increases of \$0.21 PMPM to \$1.01 PMPM. For the Medicare Advantage line of business, the statistically significant impacts ranged from decreases of \$1.22 to \$1.93. Given that ED represents a relatively small share of total medical spend,⁴ these figures should be viewed in that context; even the statistically significant results in this section reflect a small dollar impact relative to total medical.

PCP home visits

FIGURE 8: POST-REGRESSION COST COMPARISON – PCP HOME VISITS (ACCESS GROUP)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Commercial	+\$8.21	0.00	+66.1%
2023	Commercial	+\$10.01	0.00	+68.8%
2024	Commercial	+\$11.04	0.00	+69.8%
2022	Medicare Advantage	+\$26.56	0.00	+95.1%
2023	Medicare Advantage	+\$32.80	0.00	+102.3%
2024	Medicare Advantage	+\$37.24	0.00	+113.5%

PCP home visit costs were significantly higher for the access group across every line of business, year, and population cut. The magnitude of this increase was largest for Medicare Advantage (95% to 114% for the access group).

Supplementary analysis

To assess whether the findings above were consistent across member subpopulations rather than driven by a narrow subgroup, we conducted supplementary analyses by age band, MSA, and among members with a Dispatch visit.

Because members in these subpopulations may have differed systematically from the broader access-group population in ways not fully captured by the study's matching covariates, and in the case of members with a Dispatch visit, selection bias, these results are presented as supplementary rather than primary findings. Further evaluation of potential selection bias within these subpopulations is an area for future study.

Members with a Dispatch visit

We separately examined the subset of access-group members who had a Dispatch visit, identified using a list of NPIs provided by Dispatch on June 6, 2025. Because members who received a Dispatch visit likely differed systematically from the broader access-group population due to selection bias, these subgroup results do not demonstrate savings. Few results are statistically significant across member subpopulations within the Commercial line of business, so the results presented in this section are limited to Medicare Advantage.

FIGURE 9: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL (MEMBERS WITH A DISPATCH VISIT)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Medicare Advantage	-\$107.16	0.14	-8.6%
2023	Medicare Advantage	-\$141.88	0.01	-10.9%
2024	Medicare Advantage	-\$100.46	0.05	-8.2%

FIGURE 10: POST-REGRESSION COST COMPARISON – INPATIENT MEDICAL & SURGICAL (MEMBERS WITH A DISPATCH VISIT)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Medicare Advantage	-\$164.78	0.00	-39.0%
2023	Medicare Advantage	-\$217.45	0.00	-54.0%
2024	Medicare Advantage	-\$165.83	0.00	-44.7%

FIGURE 11: POST-REGRESSION COST COMPARISON – PCP HOME VISITS (MEMBERS WITH A DISPATCH VISIT)

Calendar year	Line of business	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Medicare Advantage	+\$48.76	0.00	+106.1%
2023	Medicare Advantage	+\$54.22	0.00	+111.0%
2024	Medicare Advantage	+\$57.28	0.00	+116.4%

Results for total medical showed lower PMPM costs compared to the entire access-group estimates, with 2022 showing a statistically insignificant result. PCP home-visit costs for this subgroup were higher than what was observed for the total access group, suggesting these members were using home visits more frequently, which was expected given this population directly incurred a Dispatch visit. Inpatient medical and surgical costs were lower in all three years, mirroring the access-group finding.

Age band

Figure 12 and Figure 13 present the post-regression total medical cost comparison, broken out by age band separately for the Commercial access population and the Medicare Advantage access population, ages 65+.

FIGURE 12: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL BY AGE BAND – COMMERCIAL (ACCESS GROUP)

Calendar year	Age band	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	0–17	+\$4.85	0.00	+7.2%
2023	0–17	+\$7.18	0.00	+9.0%
2024	0–17	+\$3.00	0.00	+3.3%
2022	18–25	–\$9.28	0.00	–10.5%
2023	18–25	–\$6.09	0.00	–6.4%
2024	18–25	+\$6.55	0.00	+6.9%
2022	26–35	–\$16.15	0.00	–12.9%
2023	26–35	–\$26.88	0.00	–17.6%
2024	26–35	–\$8.19	0.00	–5.4%
2022	36–45	–\$24.27	0.00	–16.0%
2023	36–45	–\$28.43	0.00	–16.0%
2024	36–45	–\$24.74	0.00	–13.8%
2022	46–55	–\$30.00	0.00	–16.6%
2023	46–55	–\$38.61	0.00	–17.3%
2024	46–55	–\$35.73	0.00	–15.4%
2022	56–64	–\$42.16	0.00	–19.1%
2023	56–64	–\$38.52	0.00	–15.0%
2024	56–64	–\$47.34	0.00	–16.6%
2022	65+	–\$66.95	0.00	–25.2%
2023	65+	–\$62.94	0.00	–19.6%
2024	65+	–\$53.74	0.00	–16.2%

FIGURE 13: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL BY AGE BAND – MEDICARE ADVANTAGE (ACCESS GROUP AGES 65+)

Calendar year	Age band	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	65–74	–\$88.94	0.00	–19.2%
2023	65–74	–\$48.68	0.00	–9.9%
2024	65–74	–\$84.16	0.00	–14.0%
2022	75–84	–\$111.98	0.00	–18.3%
2023	75–84	–\$92.92	0.00	–13.3%
2024	75–84	–\$108.44	0.00	–14.0%
2022	85–94	–\$147.25	0.00	–18.4%
2023	85–94	–\$213.66	0.00	–19.6%
2024	85–94	–\$105.76	0.01	–10.7%

Results are statistically significant in every age band and year shown. This age-based cut shows that savings within the Commercial population were more prevalent in the older subpopulations; the youngest age band shows additional medical costs for those in the access group.

The age-based cut strengthens the core Medicare Advantage finding by demonstrating that savings were not concentrated on, or dependent on, a narrow age range within the senior population.

Metropolitan Statistical Area

Figure 14 and Figure 15 present the post-regression total medical cost comparison broken out by MSA group, separately for the Commercial access population and the Medicare Advantage access population.

FIGURE 14: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL BY MSA GROUP – COMMERCIAL (ACCESS GROUP)

Calendar year	MSA group	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Everett, WA	-\$17.35	0.00	-12.4%
2023	Everett, WA	-\$15.71	0.00	-9.7%
2024	Everett, WA	-\$15.78	0.00	-8.9%
2022	Olympia-Lacey-Tumwater, WA	-\$30.29	0.00	-22.2%
2023	Olympia-Lacey-Tumwater, WA	-\$28.10	0.00	-16.0%
2024	Olympia-Lacey-Tumwater, WA	-\$28.76	0.00	-15.3%
2022	Seattle-Bellevue-Kent, WA	-\$16.90	0.00	-11.3%
2023	Seattle-Bellevue-Kent, WA	-\$28.49	0.00	-15.5%
2024	Seattle-Bellevue-Kent, WA	-\$15.80	0.00	-8.5%
2022	Spokane-Spokane Valley, WA	-\$34.25	0.00	-26.7%
2023	Spokane-Spokane Valley, WA	-\$10.50	0.00	-8.5%
2024	Spokane-Spokane Valley, WA	-\$16.69	0.00	-12.3%
2022	Tacoma-Lakewood, WA	-\$27.13	0.00	-17.9%
2023	Tacoma-Lakewood, WA	-\$26.69	0.00	-15.0%
2024	Tacoma-Lakewood, WA	-\$30.87	0.00	-16.4%
2022	Other	-\$31.49	0.00	-51.1%
2023	Other	-\$18.59	0.00	-14.7%
2024	Other	-\$33.54	0.00	-24.1%

FIGURE 15: POST-REGRESSION COST COMPARISON – TOTAL MEDICAL BY MSA GROUP – MEDICARE ADVANTAGE (ACCESS GROUP)

Calendar year	MSA group	Regression output		
		Medicare-allowed PMPM	P-value	Impact (%)
2022	Everett, WA	-\$87.75	0.00	-16.0%
2023	Everett, WA	-\$82.18	0.00	-13.3%
2024	Everett, WA	-\$74.95	0.00	-10.8%
2022	Olympia-Lacey-Tumwater, WA	-\$119.38	0.00	-24.1%
2023	Olympia-Lacey-Tumwater, WA	-\$28.31	0.26	-5.3%
2024	Olympia-Lacey-Tumwater, WA	-\$65.96	0.02	-10.2%
2022	Seattle-Bellevue-Kent, WA	-\$96.21	0.00	-17.6%
2023	Seattle-Bellevue-Kent, WA	-\$53.09	0.00	-9.1%
2024	Seattle-Bellevue-Kent, WA	-\$98.81	0.00	-13.8%
2022	Spokane-Spokane Valley, WA	-\$98.45	0.00	-19.2%
2023	Spokane-Spokane Valley, WA	-\$110.53	0.00	-17.6%
2024	Spokane-Spokane Valley, WA	-\$105.43	0.00	-15.7%
2022	Tacoma-Lakewood, WA	-\$140.85	0.00	-24.1%
2023	Tacoma-Lakewood, WA	-\$136.08	0.00	-19.5%
2024	Tacoma-Lakewood, WA	-\$117.61	0.00	-16.0%
2022	Other	-\$61.05	0.01	-19.4%
2023	Other	-\$20.32	0.57	-3.7%
2024	Other	-\$110.47	0.01	-17.9%

Commercial and Medicare Advantage results were directionally consistent (all estimates reflected savings for the access group) across every MSA and year. Although results across every MSA were significant for the Commercial population, statistical significance was not achieved in every cell for the Medicare Advantage population—notably Olympia–Lacey–Tumwater in 2023 ($p = 0.26$) and Other in 2023 ($p = 0.57$). The more populous MSAs (Everett, Seattle–Bellevue–Kent, Tacoma–Lakewood) showed statistically significant savings in every year.

Methods

Data sources

Regence and Dispatch experience claims and enrollment data

Regence provided CY 2022 to CY 2024 Commercial group and Medicare Advantage experience claims and enrollment data for members enrolled in plans including both administrative-services-only and fully insured accounts. Members with a Dispatch visit were identified within the access-group population using a list of provider NPIs, each with start and end dates reflecting when that provider was in network as a Dispatch provider (dates ranging from August 1, 2017 to December 31, 2024). See *Exclusions* below for a full list of population and claim-type exclusions applied to this data.

Market benchmark experience claims and enrollment data

We used Milliman's CHSD, a multiyear, multi-line-of-business longitudinal claims and enrollment data structure that includes over 60 million lives nationally, representing administrative healthcare claims and enrollment data from a collection of national and regional health plans, employer groups, and claim aggregators in the U.S. CHSD data was restricted to Commercial and Medicare Advantage populations residing in Washington state for CY 2022 to CY 2024 to align with the target population.

Exclusions

The following exclusions were applied to the access-group and market benchmark populations in this study:

- **Geography:** Members residing outside the included Washington MSAs (Figure 1) were excluded from both the access-group and market benchmark populations
- **Claim type:** Behavioral health claims and maternity claims were excluded from total medical costs and all supporting figures in this report, as Dispatch's service model does not focus on these categories of care
- **Outliers:** Members above the 99th percentile of Medicare-allowed cost, calculated separately by line of business, incident year, and access-group/market indicator, were excluded prior to matching to limit the influence of extreme outliers on the regression results
- **No match:** Members in the access group that lacked an adequate match in the control group were excluded from the analysis

Figure 16 reflects the impacts of excluding members with outlier costs and members lacking an adequate match.

FIGURE 16: PRE-MATCHING & POST-MATCHING MEMBERSHIP TOTALS

Calendar year	Line of business	Total membership counts		
		Pre-matching	Post-matching	Excluded (%)
2022	Commercial	132,753	131,633	1%
2023	Commercial	137,659	136,504	1%
2024	Commercial	124,566	123,484	1%
2022	Medicare Advantage	14,349	13,859	3%
2023	Medicare Advantage	14,494	13,996	3%
2024	Medicare Advantage	13,220	12,787	3%

Cost basis and repricing methodology

All medical costs in this study are reported on a 100% Medicare-allowed basis. Actual claims, which reflect payer-specific negotiated or contracted pricing, were repriced using Milliman's Medicare Repricer,⁵ which assigns Medicare-allowable fees to claims data using the 2025 Medicare fee schedule. The tool applies integrated groupers for Medicare-severity diagnosis-related groups (MS-DRG) and ambulatory payment classification (APC) to produce claim-level Medicare-equivalent pricing across inpatient, outpatient, and professional claim types. Repricing was applied to both the access-group population and the matched market benchmark population, so that both sides of the comparison were evaluated on an identical pricing basis. Claims with billed as a percentage of Medicare-allowed less than 10% or greater than 9,000% and claims with allowed as a percentage of Medicare less than 5% or greater than 2,500% were considered unreasonable and excluded from the analysis. Claims that failed to reprice were also excluded from the analysis.

This approach removes variation attributable to differences in plan-specific network pricing, contracted rates, or reimbursement methodology between Regence and the market benchmark, isolating the effect of utilization and service mix rather than underlying price differences. As a result, the savings estimates in this report can be interpreted as reflecting differences in the volume and mix of services used by the access group relative to the market, not differences in unit price or contract terms.

Analysis

We used the R package MatchIt (Version 4.7.2) in R Version 4.4.0 to perform exact and propensity-score matching to match members from the access-group and market comparison populations². Market-group members were matched to access-group members using the lowest distance in propensity scores of non-exact covariates from the cohort of market members in which all exact covariates were identical. We implemented a 1:5 nearest-neighbor matching algorithm with replacement, meaning that each member in the access group would have up to five members matched

from the market group. A control-group member may have been matched to multiple access-group members. Members were matched with a caliper of 0.2, meaning any matches with a propensity-score difference greater than 20% of the standard deviation were discarded. An average treatment effect on the treated estimand, which focuses on the effect for the Access population specifically, was used to estimate propensity scores. Exact matching was required for MSA, age band, primary CCW condition, presence of a high-acuity ED visit, incident year, and line of business; all remaining covariates listed in Figure 3 were included in the propensity score model without an exact-match requirement. Propensity scores were estimated using logistic regression, and matching was considered adequate when the SMD for each non-exact covariate was between -0.1 and 0.1 .

After matching, we assessed the impact of access-group membership on each metric endpoint using a linear regression model, controlling for the covariates listed in Figure 3. The primary result was reported as cost savings (or non-savings) based on the regression coefficient associated with access-group membership. See *Methods: Exclusions* for details on outlier removal applied prior to matching.

Discussion

Medicare Advantage: The Medicare Advantage findings formed a consistent narrative in this study. Total medical savings were statistically significant in all three years and were corroborated by two independent supplementary cuts: age band (restricted to the 65+ population) and MSA. The main drivers of cost reductions for this population were seen through reductions in inpatient medical and surgical costs (38% to 45% across all years), but these were partially offset by substantially higher PCP home visit costs (95% to 114%).

Members with a Dispatch visit: The supplementary analysis of access-group members who had a Dispatch visit had lower costs in 2023 and 2024 for Medicare Advantage (-10.9% , $p = 0.01$; -8.2% , $p = 0.05$; respectively), but this result may have been due to selection bias and should not be considered savings. Selection bias may have played a role in this subgroup: Members who received a Dispatch visit likely differed systematically from the broader access-group population in ways not fully captured by the matching covariates (e.g., acuity at time of visit, member behaviors, or provider referral patterns). We did not attempt to quantify this bias in the current study; doing so would have required additional analysis beyond the current scope, and any future work on this subgroup should treat the wide CIs and small subgroup sample sizes as a primary constraint.

Study design: This study was cross-sectional rather than pre-/post-intervention. This study employed a cross-sectional matched-comparison design, evaluating access-group members against an exact- and propensity-score-matched market benchmark within each study year, rather than a pre-/post-intervention design that would have tracked the same members' costs before and after gaining access to Dispatch's services and estimated the impact using a difference-in-differences approach. The cross-sectional approach controlled for observable differences between populations at a point in time but could not account for unobserved member-level factors that may have correlated with both selection into the access group and cost outcomes. Given data availability, a cross-sectional design was selected as the most appropriate approach for this study; results should be interpreted as correlations, not as cause and effect.

Overall, the access group had a statistically significant medical cost savings for both Commercial and Medicare Advantage lines of business across all three study years.

Qualifications

Patrick Baiza, Austin Barrington, and Erin Birkeland are members of the American Academy of Actuaries and meet the qualification standards to perform the analysis contained herein. To the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

Caveats and limitations

This report is not intended to be an endorsement of Dispatch's care-delivery model or of Regence's program design. If distributed to third parties, this report must be shared in its entirety. This analysis is intended for informational purposes only, and Milliman assumes no duty or liability to a recipient of this analysis, even if we permit distribution of our work product to such third party. This report may not be appropriate and should not be used for other purposes.

In preparing our analysis, we relied upon the accuracy of data provided to us. We have not audited this information, although we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our review may likewise be inaccurate or incomplete.

- **Exclusions:** This study applied several population and claim-type exclusions, including the exclusion of the individual line of business, behavioral health claims, and maternity claims. See *Methods: Exclusions* for the full list and rationale.
- **Cross-sectional study design:** This study used a cross-sectional matched-comparison design rather than a pre-/post-intervention design. Results should be interpreted as correlational, reflecting differences between comparable populations at a point in time, rather than as a causal estimate of the effect of an individual member gaining access to Dispatch's services. See *Discussion*.
- **Chronic condition identification:** Chronic condition presence was identified using CMS CCW definitions¹ based on diagnosis codes present on any claim in a given study year. Once a member was flagged with a condition in any study year, that condition was carried forward and applied to all subsequent years for that member, regardless of whether a corresponding diagnosis code appeared in claims for the later year. As a result, condition prevalence in earlier years may be understated relative to later years (a condition first diagnosed in 2023 would not be reflected in a member's 2022 flag), and the approach does not capture resolution or remission of a condition. This is a reasonable simplification given data limitations, but the condition-level cuts in this report should be read as identifying members with a history of a condition during the study window, not necessarily active treatment or diagnosis in every year shown.
- **Members with a Dispatch visit – selection bias:** Results for the subgroup of access-group members who had a Dispatch visit are supplementary and should be interpreted with caution. This subgroup is materially smaller than the full access group, producing wider CIs and, in most year/line-of-business scenarios, results that are not statistically significant. We believe members who received a Dispatch visit likely differed systematically from the broader access-group population in ways not fully captured by the study's matching covariates. Quantifying this selection bias was outside the scope of the current study.
- **Data source variation:** CHSD comprises several unique data contributors that may reflect differences from Regence's experience in reported allowed dollars, unit coding, and other data attributes.
- **Small-sample instability in supplementary analyses:** Several supplementary analyses by age band, MSA, and chronic condition, as shown in Figure 12, Figure 13, Figure 14, and Figure 15, include cells with small underlying sample sizes, producing wide CIs and non-significant results.

Models used in the preparation of our analysis were applied consistently with their intended use. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose, as well as compliance with generally accepted actuarial practice and relevant actuarial standards of practice. The models, including all inputs, calculations, and outputs, may not be appropriate for any other purpose.

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