MILLIMAN REPORT

Potential cost deflection of Healthcare2U's Direct Primary Care Advantage model

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Table of contents

EXECUTIVE SUMMARY **1**
1. BACKGROUND **3**
2. THE DPCADVANTAGE MODEL **3**
3. ANALYSIS AND FINDINGS **7**
4. LIMITATIONS **13**
5. METHODOLOGY **15**
6. CAVEATS AND LIMITATIONS **16**
APPENDIX A **17**
APPENDIX B **20**
APPENDIX C **25**

Executive summary

Healthcare2U (HC2U) engaged Milliman to perform an illustrative assessment of the potential financial impact of its DPCadvantage program on self-funded employer healthcare costs based on a set of cost deflection assumptions defined by HC2U. DPCadvantage is a hybrid direct primary care (DPC) model that employers purchase on a per-employee basis, offering care via both in-person and telehealth appointments. The model's foundational premise is that a meaningful share of routine, avoidable, and manageable healthcare utilization currently flows through traditional fee-for-service claim pathways at unnecessarily high cost, and that a well-designed primary care access and navigation infrastructure can redirect a substantial portion of that utilization into lower-cost settings before expenses escalate. By increasing access to primary care through 24/7 primary care availability, $0 visits for primary care and chronic disease management, and urgent care coverage, as well as other key product features, HC2U believes it can reduce the overall cost of healthcare for employers.

Milliman used its proprietary Consolidated Health Cost Guidelines Sources Database (CHSD) to randomly simulate employer groups. Select groups were then combined to create three cohorts for the analysis (low risk, average risk, and high risk) in order to study how the financial impact associated with a set of cost deflection assumptions could vary based on different employer risk profiles. Subsets of each risk cohort were also created to study how cost deflection results could vary based on the different mix and volume of services provided to members who had at least one of HC2U's 13 focus conditions present during the study period, and those who did not.

Healthcare services that could plausibly be deflected by HC2U's program were identified in each cohort and its corresponding subsets, and HC2U's assumed deflection percentages were applied to the deflectable services to estimate potential employer savings. Results are provided both gross and net of HC2U's monthly fees. We reviewed HC2U's deflection assumptions for reasonableness by conducting a literature review on other interventions used in the market.

Key findings are summarized in Figure 1:

- After deducting HC2U's program fee, estimated net deflected costs were between $3 and $24 per member per month (PMPM) across the low-, average-, and high-risk cohorts, representing between 0.6% and 3.4% of total employer paid claims costs.
- For the average-risk cohort, net deflected cost was $18 PMPM—approximately 3.1% of total employer costs—resulting in a calculated, illustrative hypothetical return on investment (ROI) of 1.4-to-1. This hypothetical ROI is based on achieving the deflection assumptions modeled.
- Across all three risk cohorts, cost deflection PMPM was higher for member subsets having at least one focus condition, and lower for subsets with no focus conditions.
    - Estimated net deflected costs for members with at least one focus condition were between $23 and $54 PMPM, representing between 3.2% and 4.4% of total employer paid costs.
    - For members with no focus conditions, there were no savings. Rather, employer costs are estimated to be $6–$17 PMPM higher through the HC2U program than costs through traditional healthcare providers.

These results are based on HC2U's assumed deflection percentages for illustrative purposes only. They do not represent estimates of savings derived from any actual results from employers who have engaged HC2U. This analysis represents a feasibility analysis only and makes no statements as to whether the savings can be or have ever been achieved. This analysis is assumption-driven and presents scenarios that only indicate the possibility of financial outcomes under those assumptions. Moreover, actual savings will vary materially by employer depending on each employer's specific population size, demographics, benefit design, program utilization, risk profile and mix of services utilized, among other variables.

FIGURE 1: NET DEFLECTED HEALTHCARE COSTS BY EMPLOYER RISK PROFILE AND FOCUS CONDITION STATUS

	Risk profile	All members	Members with at least one focus condition	Members with no focus conditions
PMPM	Low risk	$3	$23	-$17
	Average risk	$18	$43	-$7
	High risk	$24	$54	-$6
% of Total	Low risk	0.6%	3.2%	-11.9%
	Average risk	3.1%	4.4%	-4.3%
	High risk	3.4%	4.3%	-3.8%

1. Background

Employer-sponsored health benefits remain one of the largest and most unpredictable operating costs for many organizations. Traditional, open-access, fee-for-service network insurance models may not have the structure or provide enough incentives to redirect members to lower-cost care settings. As a result, employers have increasingly been looking for alternative, third-party solutions to improve financial results for their plan and outcomes for their employees.

This report examines the DPCadvantage program offered by Healthcare2U (HC2U), which operates in conjunction with an employer's existing health plan and utilizes, among other things, features of direct primary care (DPC) to help employers control costs. In exchange for a per contract per month payment from the employer, HC2U's model aims to generate savings on fee-for-service claim costs for employers by handling a meaningful share of primary and ancillary care outside of the traditional insurance claims process at a lower cost than would otherwise be incurred in a traditional provider setting. In certain cases, HC2U claims that some healthcare costs can also be eliminated due to improved access to primary care.

HC2U engaged Milliman to perform a feasibility analysis to determine the assumptions that are required for a program such as DPCadvantage to generate net savings for employers after accounting for program fees. This analysis uses Milliman’s proprietary claims data, publicly available data, and HC2U's assumed deflection percentages. It does not constitute an evaluation of the actual effectiveness of the HC2U model as it does not examine any outcomes generated by employer groups engaged with HC2U. While the analysis does rely on actual employer group claims data, the modeled groups are synthetic, created by stochastic modeling, and do not represent any actual employer.

Moreover, the deflection assumptions are provided by HC2U and represent their best estimates of potential deflection. These assumptions are not derived from or validated by actual program experience. While we provide a short literature review to support the notion that savings in medical and prescription drug costs are achievable when specific actions related to medical management and plan design are taken, we are unable to independently verify that the deflection assumptions used in this modeling can be achieved by HC2U, as there is no program outcome data available.

2. The DPCadvantage model

The following is our understanding of the DPCadvantage model based on conversations with Healthcare2U. It serves as the basis for the modeling and analysis that follows.

HC2U's DPCadvantage is a monthly fee-based model, sold to employers on a per-employee basis. Covered services in exchange for this fee include unlimited primary care visits at $0 member cost sharing utilizing providers who actively screen for and manage 13 chronic conditions, 24/7 virtual care, urgent care, diagnostic imaging, and pharmacy and lab discount programs. These benefits are available only at HC2U-contracted providers and only when accessed through HC2U's dedicated patient advocacy line (PAL). Contracted providers commit to generic-first prescribing protocols, same-day or next-day appointments, and focused treatment on 13 chronic conditions.

Care delivery begins with HC2U's team of certified medical assistants, who triage member needs, coordinate appointments, and route individuals to the appropriate provider within HC2U's network. The program emphasizes speed of access—members can typically be seen same-day or next-day—contrasting with average wait times of 20 days or more, which are commonly experienced in traditional primary care settings.[1]

HC2U's private physician network (PPN) is built through direct physician contracting, enabling consistent access for geographically dispersed employee populations. The network design supports portability when employees relocate or travel. HC2U also uses a proprietary electronic medical record (EMR) system and a care coordination model to maintain continuity as members move between care settings or providers. This is designed to reduce duplicative testing and care fragmentation, which can otherwise drive avoidable costs.

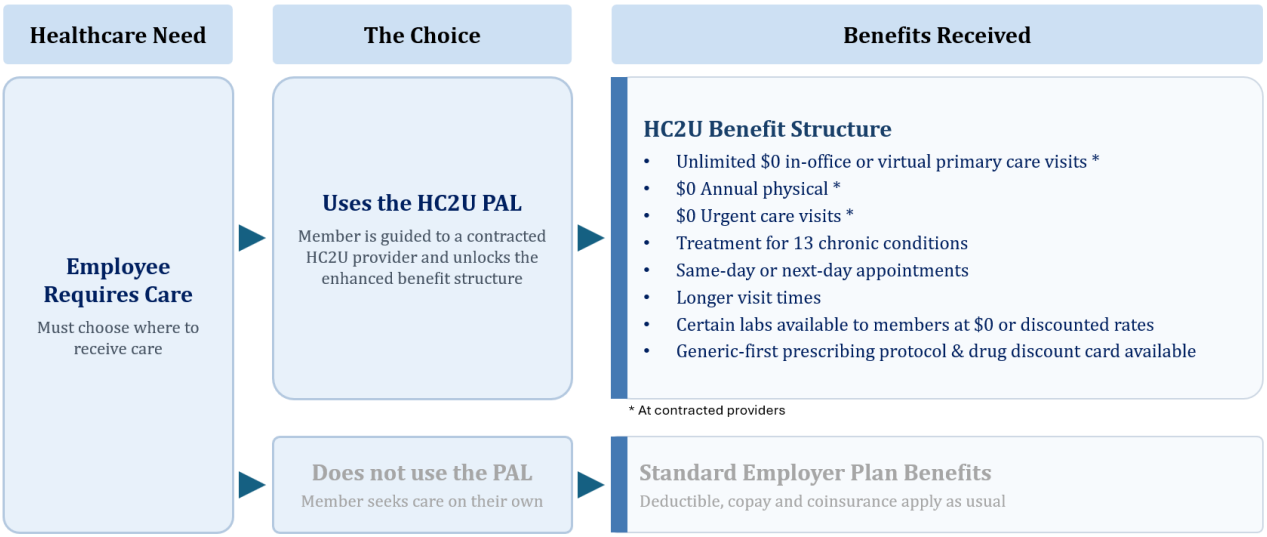
The program's financial premise is straightforward: Care handled within the HC2U model generally does not generate health insurance claims, reducing the employer's total claims cost. The program targets primary care, specialist visits for 13 chronic conditions, urgent care, and ancillary services. If a member requires care beyond what the HC2U model can address, HC2U helps identify appropriate in-network solutions and directs the member to providers within the employer's traditional healthcare network. This care navigation is integrated into the HC2U model at no additional cost to employers.

Pharmacy and laboratory savings are embedded in the program as well. HC2U uses a generic-first prescribing protocol and offers a drug discount card for additional savings on covered medications. Lab services for certain chronic conditions are covered at $0 for members, with additional labs available at discounted rates to members.

Figure 2 outlines the healthcare journey for members with HC2U benefits. Members must first decide whether they will seek care through the HC2U patient advocacy line (PAL) or on their own. HC2U strongly encourages employers to list their PAL phone number prominently on ID cards to steer as much care as possible into the program, deflecting care away from traditional health plan providers where visits would be billed to the employer.

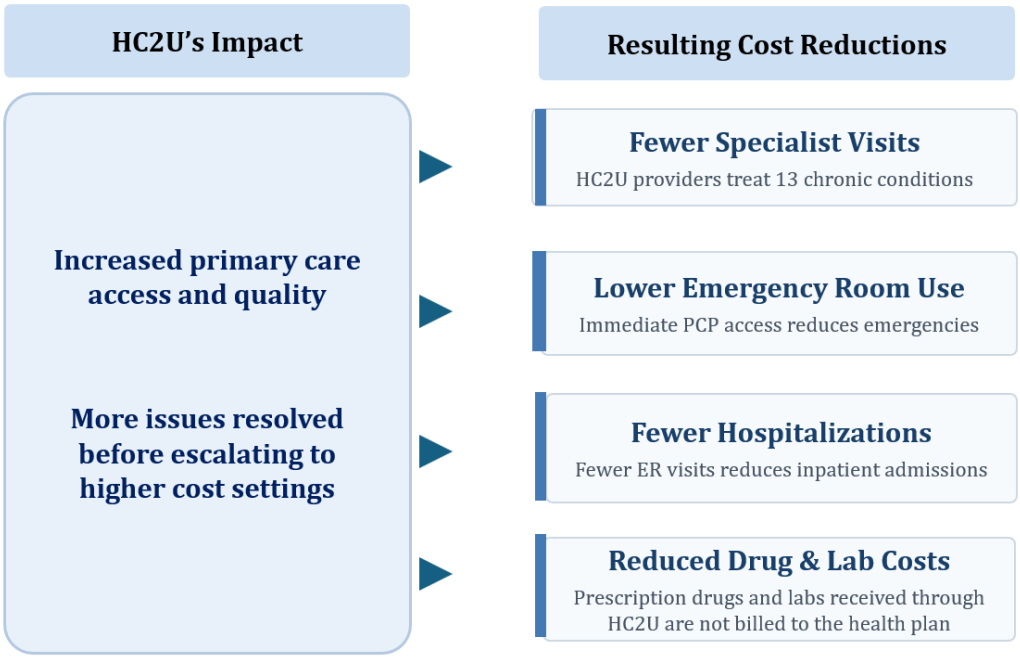
[1] AMN Healthcare (Merritt Hawkins). (2024, August 8). 2022 survey of physician appointment wait times and Medicare and Medicaid acceptance rates. Available from https://www.amnhealthcare.com/amn-insights/physician/whitepapers/survey-of-physician-appointment-wait-times.

FIGURE 2: HEALTHCARE JOURNEY FOR MEMBERS WITH HC2U BENEFITS



When a member chooses to receive care through HC2U, the benefit structure is designed to increase primary care access and quality, ultimately resulting in fewer medical issues needing escalation to higher cost settings such as ED visits or inpatient admissions. Figure 3 summarizes the potential cost reductions resulting from HC2U's benefit structure.

FIGURE 3: POTENTIAL HEALTHCARE COST REDUCTIONS RESULTING FROM HC2U'S BENEFIT STRUCTURE



HC2U's program aims to reduce specialty costs by providing care management for 13 chronic conditions through the contracted network of PCPs, thereby reducing the need to seek care from higher-cost specialist providers. For chronic conditions, continuity of care and proactive treatment of risk factors can improve health, prevent or delay complications, and reduce hospitalizations. As a specific example, research has shown that early detection and active management of type 2 diabetes mellitus in a primary healthcare setting reduces or defers onset of

complications requiring specialist visits.[2] In another study, PCPs' use of e-consultations with specialists (in lieu of an in-person visit) improved access to care, reduced overall specialty utilization, and streamlined specialty referrals without any increase in adverse cardiovascular outcomes.[3]

Increased primary care access has also been shown to reduce emergency department (ED) use. One study found that extending routine and urgent care access to evenings and weekends was associated with a 26.4% relative reduction in patient-initiated ED visits for "minor" problems.[4] Research shows that for adults with chronic conditions, having a set source of primary care lowered their odds of ED visits and inpatient admissions by 11% and 20%, respectively, and was associated with having nearly 54% lower total healthcare expenditures.[5]

The ED is the origin of about half of all inpatient admissions and of almost all inpatient admission growth.[6] Most ED visits that lead to hospital admission are considered intermediate severity. Examples of intermediate severity include flare-ups of chronic conditions, such as congestive heart failure or high blood sugar in people with diabetes. Patients with chronic conditions often return to the ED or are readmitted because they feel they cannot get timely follow-up care. Making sure patients can quickly see a primary care provider after an ED visit can reduce repeat ED visits and hospitalizations.[7] Based on our conversations with management, HC2U believes its program is positioned to provide access to this follow-up care, helping to reduce employer costs for these services.

A list of references that support the feasibility of savings when interventions similar to HC2U's model are undertaken is found in Appendix C.

Prescription drug costs are expected to decrease through a generic-first prescribing protocol and the availability of a member drug discount card. Prioritizing generics reduces the likelihood that higher-cost brand medications are filled through the traditional health plan, thereby limiting employer cost exposure. Discounted generic pricing may also encourage members to pay out of pocket through the program, further reducing employer responsibility.

[2] Comino, E.J., et al. (2012, November 21). A systematic review of interventions to enhance access to best practice primary health care for chronic disease management, prevention and episodic care. *BMC Health Services Research*, 12, 415 (2012). Retrieved September 8, 2026, from https://doi.org/10.1186/1472-6963-12-415.

[3] Olayiwola, J.N., Anderson, D., Jepeal, N., Aseltine, R., Pickett, C., Yan, J., & Zlateva, I. (March 2016). Electronic consultations to improve the primary care-specialty care interface for cardiology in the medically underserved: A cluster-randomized controlled trial. *Annals of Family Medicine*, 14(20), 133–140. Retrieved September 8, 2026, from https://pmc.ncbi.nlm.nih.gov/articles/PMC4781516.

[4] Whittaker, W., et al. (2016, September 6). Associations between extending access to primary care and emergency department visits: A difference-in-differences analysis. *PLOS Medicine*, 13(9). Retrieved September 8, 2026, from https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002113

[5] Jabbarpour, Y., Jetty, A., Byun, H., Siddiqi, A., Park, J., Robert Graham Center, & Koller, C. (2026). Investing in primary care: The missing strategy in America's fight against chronic disease. Retrieved September 8, 2026, from https://www.milbank.org/wp-content/uploads/2026/02/MillbankInvestinginPrimaryCareReportACCESSv04_Final.pdf.

[6] Gonzalez Morganti, K., et. al. (2013). The evolving role of emergency departments in the United States. RAND Corporation. Available from https://www.jstor.org/content/oa_book_monograph/10.7249/j.ctt3fh1ft.

[7] Carmel, A.S., Steel, P., Tanouye, R., Novikov, A., Clark, S., Sinha, S., & Tung, J. (2017, July 14). Rapid primary care follow-up from the ED to reduce avoidable hospital admissions. *Western Journal of Emergency Medicine*, 18(5), 870–877. Retrieved September 8, 2026, from https://pmc.ncbi.nlm.nih.gov/articles/PMC5576623.

3. Analysis and findings

Average risk cohort analysis

We began by building a reference population using Milliman's Consolidated Health Cost Guidelines Sources Database (CHSD), consisting of approximately 100,000 commercial group members with continuous enrollment throughout 2024. From the reference population, we created sample 100-member groups and combined them to develop low-risk, average-risk, and high-risk cohorts (see Section 4 for full methodology details). The focus of this section is the analysis developed for the average-risk cohort. In the following section, we examine how results differ across various population risk profiles and between subgroups with varying mix of services utilized due to presence of chronic condition(s).

For the average-risk cohort, we identified the portion of healthcare costs that could plausibly be deflected by HC2U's program—referred to as “impactable costs.” Specialist costs were limited to treatments for HC2U's 13 focus conditions (Figure 4). Primary care visits for children under age 2 were excluded to align with HC2U’s focus on members over age 2. Pharmacy costs exclude specialty drugs, which are typically out of scope for HC2U providers. Lab costs were limited to include only the list of labs currently offered through the HC2U program, separated by amount of member cost-sharing applied (either $0 or discounted rate). Urgent care, emergency care, and inpatient care claims were included in full. While emergency and inpatient care are not services directly provided by HC2U, these services are considered impactable because the program’s focus on providing same-day or next-day care and chronic condition management are believed to reduce the need for ED visits, which in turn reduces inpatient admissions.

FIGURE 4: HC2U’S 13 FOCUS CONDITIONS

Actual impactable costs will differ from the average-risk population shown depending on several variables, including, but not limited to:

- Population demographics (age, sex, geographic location, etc.)
- Volume of services redirected to the HC2U program
- Underlying traditional health plan benefits
- Population risk profile or health status
- Mix of services utilized

We discuss other risk profiles later in this document.

We applied HC2U's assumed cost deflection percentages (Figure 5) to the impactable costs PMPM to estimate gross deflected costs. Cost deflection is defined as eliminating costs that would otherwise have been the liability of the traditional health plan. The cost deflection percentages are not based on any study or publication but rather serve as HC2U’s hypothetical estimates of potential cost deflection resulting from their program’s specific model of care. We used these values as provided and did not conduct any analysis to confirm the validity of such values. They are for illustrative purposes only and are not derived from empirical program data. We provide a brief literature review in Appendix C, which serves as contextual data on the reasonableness of key savings assumptions.

FIGURE 5: HC2U'S ASSUMED COST DEFLECTION PERCENTAGES

Service category	Deflection %
PCP	50%
Emergency	50%
Diagnostic radiology	40%
Specialist	30%
Urgent care	25%
Lab services (Covered at $0)	20%
Prescription drugs	15%
Inpatient care	10%
Lab services (covered for a fee)	10%
Psychology/psychiatry	10%

The highest deflection rates apply to PCP and emergency services (50% each), reflecting HC2U's core value proposition: unlimited $0 primary care incentivizing members to seek a PCP outside of the traditional health plan (and thereby at no cost to the employer), and 24/7 virtual access that reduces unnecessary ED visits. The relatively lower deflection rate for inpatient care (10%) acknowledges that this high-cost category may be only slightly influenced by factors other than primary care program design.

Figure 6 summarizes the estimated costs PMPM for impactable services by service category and applies HC2U's cost deflection percentages to each, demonstrating potential deflected costs PMPM for the average-risk cohort. Under these deflection assumptions, we estimate $63 PMPM could be deflected from employer responsibility, which represents approximately 11% of total employer paid costs.

FIGURE 6: GROSS DEFLECTED COSTS BY SERVICE CATEGORY AVERAGE RISK COHORT

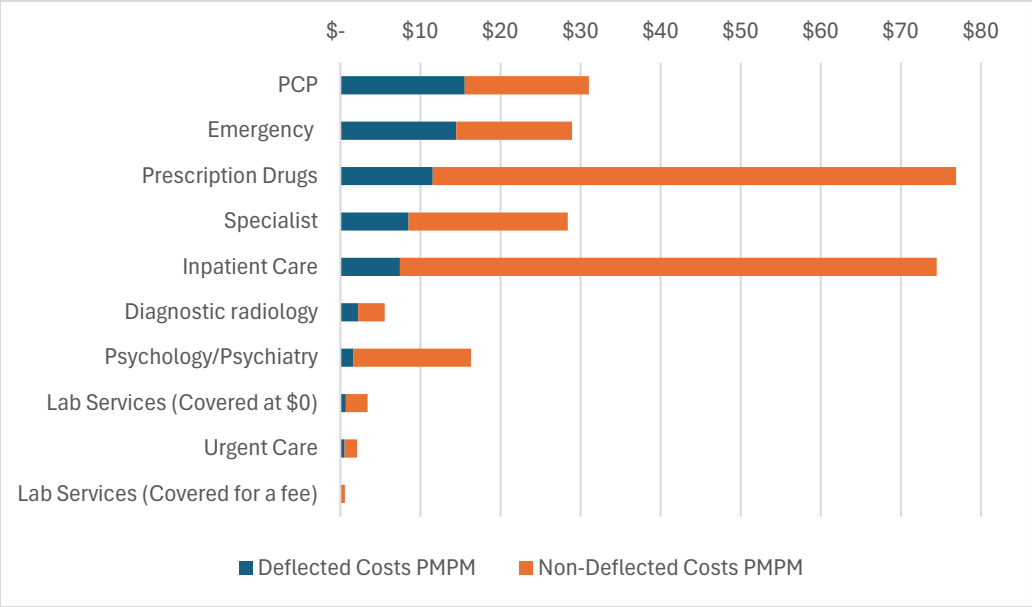
Service category	Paid PMPM	Deflection %	Deflected costs PMPM
PCP	$31	50%	$16
Emergency	29	50%	14
Prescription drugs	77	15%	12
Specialist	28	30%	9
Inpatient care	74	10%	7
Diagnostic radiology	6	40%	2
Psychology/psychiatry	16	10%	2
Lab services (covered at $0)	3	20%	1
Urgent care	2	25%	1
Lab services (covered for a fee)	0.56	10%	0.06
Total paid for impactable services	$268		$63
Total paid for non-impactable services	$303		% deflected
Grand total paid	$571		11.0%

For the average-risk cohort, total impactable costs were $268 PMPM—approximately 47% of the total employer-paid costs of $571 PMPM. Prescription drugs ($77 PMPM) and inpatient care ($74 PMPM) represented the largest impactable cost categories, together accounting for over half of the $268 PMPM total. While these are significant in

absolute terms, their potential impact depends on the deflection rates applied—categories with moderate costs but high deflection rates can have a larger impact than larger categories with lower deflection rates.

For example, despite being the largest impactable service categories, prescription drugs and inpatient care contribute a smaller share of total deflected savings compared to other categories. Figure 7 shows that PCP and emergency services actually generate the highest estimated cost deflection, driven by their higher deflection percentages of 50%. Together, these two categories account for about $30 PMPM—nearly half of total deflected costs—despite representing only about one-fifth of total impactable costs.

FIGURE 7: DEFLECTED COSTS IN RELATION TO TOTAL IMPACTABLE COSTS



Variations by risk profile and mix of services utilized

Savings potential can vary significantly based on the risk profile and health complexity of an employer's population. Figure 8 presents gross deflected costs for members across three risk cohorts: low risk, average risk, and high risk. (See Appendix A for detail by service category.) In addition, two mutually exclusive subgroups are broken out for each cohort to demonstrate variation by mix of services utilized:

- Members with at least one of HC2U's 13 focus conditions
- Members with no focus conditions

Gross deflected costs range from $28 PMPM (low risk, members with no focus conditions) to $98 PMPM (high risk, members with a focus condition). Higher-risk populations with more complex conditions can drive greater savings than lower-risk populations, primarily through higher utilization of specialist and inpatient services.

FIGURE 8: GROSS DEFLECTED HEALTHCARE COSTS BY RISK PROFILE AND MIX OF SERVICES UTILIZED

	Risk profile	All members	Members with at least one focus condition	Members with no focus conditions
PMPM	Low risk	$47	$68	$28
	Average risk	$63	$88	$38
	High risk	$69	$98	$38
% of total	Low risk	11.2%	9.4%	19.8%
	Average risk	11.0%	9.0%	22.4%
	High risk	9.7%	7.9%	22.8%

Figure 8 also demonstrates how potential claims savings can vary based on the mix of services utilized. Across all risk levels, members managing at least one of HC2U's 13 focus conditions have about 40% to 45% higher gross deflected costs PMPM compared to the total population within a given risk cohort. This reflects higher-than-average utilization of healthcare services among members with chronic conditions—precisely the services HC2U's program targets. Employers with a higher prevalence of chronic conditions in their workforce could therefore expect greater gross savings PMPM compared to employers that do not. In contrast, members with no focus conditions have about 40% to 45% lower gross deflected costs PMPM compared to the total population within a given risk cohort.

While gross deflected costs PMPM are consistently lower for low-risk subsets and higher for high-risk subsets, when stated on a percentage of total paid claims basis, deflected costs are relatively similar across risk levels, ranging between approximately 10% and 11%. The range was similar for subgroups with at least one focus condition (about 8%–10%). However, the range was highest for members with no focus conditions—about 20%–23%—because their ED costs make up a much larger portion of total impactable costs. Applying a deflection percentage of 50% to a larger portion of claims results in a comparatively higher portion of deflected costs as a percentage of total costs. The use of a single set of deflection assumptions across the risk profiles is a simplifying assumption. See Section 4: Analysis Limitations

Figure 9 summarizes the net impact of the cost of the HC2U program fees. The PMPM savings estimates vary between $3 and $54 across all risk cohorts for all members and also for the subset of members with at least one focus condition. However, for the subsets of members with no focus conditions, there are no savings. Rather, it would cost employers between $6 and $17 PMPM more to purchase the HC2U program net of the cost savings they are expected to realize from it. This highlights the importance of population composition in evaluating HC2U's program value. Employers should model their own expected distribution across these segments to arrive at a realistic net savings estimate.

To calculate net deflected costs, we subtract HC2U's program fee from gross deflected costs. We converted HC2U’s four-tier 2024 rating structure to a PMPM amount using standard commercial demographic assumptions from the 2026 Milliman Healthcare Cost Guidelines. This resulted in an average program cost PMPM of $44.80. Net savings for the average-risk cohort are $18 PMPM—approximately 3.1% of total employer costs—resulting in a hypothetical ROI of 1.4-to-1.

FIGURE 9: NET DEFLECTED HEALTHCARE COSTS BY RISK PROFILE AND MIX OF SERVICES UTILIZED

	Risk profile	All members	Members with at least one focus condition	Members with no focus conditions
PMPM	Low risk	$3	$23	-$17
	Average risk	$18	$43	-$7
	High risk	$24	$54	-$6
% of total	Low risk	0.6%	3.2%	-11.9%
	Average risk	3.1%	4.4%	-4.3%
	High risk	3.4%	4.3%	-3.8%

Variations by deflection intensity

Savings potential can also vary by the intensity of deflection assumed. Three sets of deflection assumptions were created to study the sensitivity of results with respect to varying levels of deflection. In Figure 5, we outlined the set of baseline deflection percentages that were applied to our sample populations thus far in the study. Using these baseline values as our average deflection, we developed low- and high-deflection scenarios in relation to the average. The various deflection intensity scenarios are outlined below in Figure 10.

FIGURE 10: COST DEFLECTION ASSUMPTIONS BY DEFLECTION INTENSITY SCENARIO

	Deflection intensity		
Service category	**Low**	**Average**	**High**
PCP	40%	50%	60%
Emergency	40%	50%	60%
Diagnostic radiology	30%	40%	50%
Specialist	20%	30%	40%
Urgent care	15%	25%	35%
Lab services (covered at $0)	15%	20%	25%
Prescription drugs	10%	15%	20%
Inpatient care	5%	10%	15%
Lab services (covered for a fee)	5%	10%	15%
Psychology/psychiatry	5%	10%	15%

Gross and net deflected costs were then calculated for each of the three population risk cohorts (low risk, average risk, high risk). The results are summarized in figures 11 and 12, respectively. (See Appendix B for detail by service category.)

FIGURE 11: GROSS DEFLECTED HEALTHCARE COSTS BY RISK PROFILE AND DEFLECTION INTENSITY

		Deflection intensity		
	Risk profile	**Low**	**Average**	**High**
PMPM	Low risk	$34	$47	$60
	Average risk	$44	$63	$81
	High risk	$49	$69	$89
% of Total	Low risk	8.2%	11.2%	14.3%
	Average risk	7.8%	11.0%	14.2%
	High risk	6.9%	9.7%	12.5%

FIGURE 12: NET DEFLECTED HEALTHCARE COSTS BY RISK PROFILE AND DEFLECTION INTENSITY

		Deflection intensity		
	Risk profile	**Low**	**Average**	**High**
PMPM	Low risk	-$10	$3	$15
	Average risk	$0	$18	$36
	High risk	$4	$24	$44
% of Total	Low risk	-2.4%	0.6%	3.7%
	Average risk	-0.1%	3.1%	6.3%
	High risk	0.6%	3.4%	6.2%

Across all risk levels, gross cost deflection PMPM was $13–$20 lower than average under the low-deflection scenario and $13–$20 higher under the high-deflection scenario, representing a deviation of more than 25% in either direction. This sensitivity analysis demonstrates that even modest 5%–10% changes in deflection assumptions can materially affect estimated program savings. These findings underscore the importance of evaluating a broad range of assumptions when developing realistic savings estimates for a given employer.

4. Analysis limitations

This feasibility study has several limitations that might make the modeled financial results higher or lower than shown, even assuming deflection percentages are achieved.

Uniform Deflection Assumptions Across Risk Profiles

For simplicity of modeling and limiting the number of scenarios, we make a simplifying assumption that deflection percentages are the same across the employer risk levels modeled. In reality, differing risk profiles will likely drive different deflection results. As an example, a healthier cohort likely uses less emergency department care but when it is utilized, the intensity of the services provided will be higher as it is likely a bona fide emergency. Moreover, it is unlikely this utilization could be deflected. In contrast, higher risk populations that have more chronic conditions may have more ED utilization but at lower intensity and this care is likely more deflectable. Similar dynamics could be present across all service categories, as well.

Short-term versus longer-term savings: The nature of the deflected costs shown in this model are essentially immediate- to short-term savings. They represent the prevention of various higher-cost services received in higher-cost settings and the substitution of lower cost of care settings, primarily the PCP's office. The mechanism for these savings is primarily, but not exclusively, improved access to the contracted PCPs, which results in same-day or next-day appointments. It is possible that a consistent, longitudinal relationship with a PCP that is focused on management of chronic conditions could result in improved health outcomes beyond the short-term results in this analysis. Although this is an intuitive and likely noncontroversial assertion that is widely held, there are very few long-term, actuarially sound studies to support the claim.

Healthcare cost fluctuations: Fluctuations in claims costs are normal for all employer groups and can be material for smaller employers. Catastrophic costs, again for smaller employers, can overwhelm the impact of any other cost sharing initiatives or programs that an employer puts in place. The results shown here are effectively longer-term averages of claims costs for synthetic employer groups of 100 employees. Annual differences from these average claims costs will produce different financial results—positive or negative—relative to what is shown in this analysis.

Physician practice patterns: An unknown but significant driver of potential favorable or unfavorable results rests in the execution by contracted physicians of the sources of value in the HC2U solution. Specifically: ensuring that patients receive same- or next-day attention, controlling specialist referrals (including the use of e-consults), adhering strictly to generic first protocols, extending visit times to ensure optimal attention to patients, and providing quality care to those with focus chronic conditions. It is certain that not all providers will perform these actions consistently to the highest level. Moreover, existing provider practice patterns may vary by geographic area and may be more or less conducive to modification when HC2U contracts with them.

Underlying benefit design: HC2U works in conjunction with an employer's underlying major medical benefit plan design. Even in the absence of HC2U, benefit design is a powerful lever to drive overall utilization by employees, as well as utilization steerage to various sites of care or types of providers. In the context of the HC2U overall, the impact of HC2U can be influenced—positively or negatively—by the employer's benefit plan offerings. For example, it is unlikely that a contracted PCP can have as much impact on utilization of the ED if the copay for an ED visit is $0.

The exact benefit structure of the underlying claims used for this feasibility study is not known as it is a deidentified aggregation of thousands of employers. However, for calendar 2024 (the year used for this study), a reasonable estimate of a typical/average benefit design can be found at the Kaiser Family Foundation website[8] and suggests the following:

- The comprehensive deductible was ~$1,800.
- The global coinsurance was ~20%.
- The PCP copay was ~$25.

[8] Claxton, G., et al. (2024). "2024 Employer Health Benefits Survey. KFF. Retrieved September 8, 2026, from https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf.

- The specialist copay was ~$46.
- ED cost sharing was unavailable.
- Maximum-out-of-pocket (MOOP) was unavailable.

5. Methodology

Deflection assumptions were defined by HC2U. Milliman performed a limited review and a limited literature search to provide context for these assumptions. Management of HC2U provided what is considered the average deflection intensity. To provide additional ranges, Milliman adjusted the average assumptions up and down by an arbitrary but, what we believer to be reasonable amounts.

The analysis utilizes Milliman's full Consolidated Health Cost Guidelines Sources Database (CHSD) member population and applied a series of eligibility and data quality filters to define the study population for calendar year 2024. Specifically, the population was restricted to:

- Commercial group members
- Members not flagged as outliers;
- Members with continuous enrollment throughout 2024, defined as 12 months of both medical and pharmacy eligibility

This filtered population formed the basis for all sampling and cohort development. The resulting claims were incurred during calendar year 2024, paid through December 31, 2025, and were not trended forward or adjusted for development.

Sampling framework

From the filtered population, we drew a random initial sample of approximately 100,000 members, each assigned to one of 1,000 groups of 100 members. This two-stage sampling approach reduces the influence of any single high-cost member on the reference population and produces a stable, representative baseline.

For each 100-member group, we calculated total allowed cost per member per month. Averaging across all 1,000 groups defined the baseline cost and risk level.

Development of risk cohorts

Three cohorts were constructed to represent low-, average-, and high-cost employer populations, each consisting of 50 non-overlapping groups of 100 members drawn to meet a target cost level relative to the baseline:

The cohort targets were defined relative to the baseline average cost:

- **Low-risk cohort:** approximately 75% of baseline cost
- **Average-risk cohort:** approximately 100% of baseline cost
- **High-risk cohort:** approximately 125% of baseline cost

Cohorts were assembled by randomly drawing 50 groups from the 1,000 available and evaluating the resulting average cost against the target. For the low-risk cohort, groups were selected with below-average costs; for the high-risk cohort, groups with above-average costs were selected. Selection continued iteratively until the cohort average fell within an acceptable range (i.e., +/- 1%) of the target.

Condition-based subgroups

Within each risk cohort, members were further divided based on the presence of HC2U's 13 focus conditions (Figure 4). Presence of a focus condition is based on ICD10 coding and a condition grouping software. Subset populations were defined by including only members that had at least one of HC2U's 13 focus conditions identified during the study period.

6. Caveats and qualifications

The purpose of this report is to illustrate the set of deflection assumptions required for a program such as Healthcare2U's DPCadvantage to generate various levels of net savings for various employer risk levels. It should not be used to predict or guarantee actual financial outcomes for any specific employer group or for any other purposes.

This report was commissioned by and prepared for the management of Healthcare2U (HC2U). Milliman makes no representations or warranties to any third party. Third parties are instructed to place no reliance on this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees such third parties. Any reliance on the Milliman report is entirely at one's own risk. Milliman shall not be liable for any loss, damage, or expense of any nature caused by one's reliance upon the Milliman report.

The analysis draws on Milliman's proprietary claims database, publicly available data, and HC2U-provided deflection assumptions. The latter information was accepted as provided, without independent audit or verification.

The analysis is based on commercial health insurance data only. It does not evaluate the potential impact on Medicare, Medicaid, or other noncommercial populations.

We developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output, may not be appropriate for any other purpose.

The results in this report depend on specific assumptions and methodologies. Applying them in other contexts or without understanding the underlying assumptions could lead to incorrect conclusions. Users should review Section 4 (Methodology) before drawing conclusions from this report.

Results can vary for any number of reasons not explicitly captured in the modeling including but not limited to random claims variability, large claims, sampling variability and claims adjudication practices of various payers. Any reader of this report should closely review the Analysis Limitations in Section 4.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Fritz Busch and Bridgett McCarthy are members of the American Academy of Actuaries and meet its Qualification Standards to render the actuarial opinion contained herein.

Appendix A

Gross deflected costs by population subset

Low-risk cohort—all members			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$26	50%	$13
Emergency	22	50%	11
Prescription drugs	66	15%	10
Specialist	25	30%	7
Inpatient care	21	10%	2
Diagnostic radiology	5	40%	2
Psychology/psychiatry	7	10%	1
Lab services (covered at $0)	3	20%	1
Urgent care	2	25%	1
Lab services (covered for a fee)	0.50	10%	0.05
Total	$178		$47
Total paid for non-impactable services	$245		% deflected
Grand total paid	$423		11.2%

Average-risk cohort—all members			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$31	50%	$16
Emergency	29	50%	14
Prescription drugs	77	15%	12
Specialist	28	30%	9
Inpatient care	74	10%	7
Diagnostic radiology	6	40%	2
Psychology/psychiatry	16	10%	2
Lab services (covered at $0)	3	20%	1
Urgent care	2	25%	1
Lab services (covered for a fee)	0.56	10%	0.06
Total paid for impactable services	$268		$63
Total paid for non-impactable services	$303		% deflected
Grand total paid	$571		11.0%

High-risk cohort—all members			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
Emergency	$35	50%	$17
PCP	32	50%	16
Prescription drugs	79	15%	12
Specialist	33	30%	10
Inpatient care	91	10%	9
Diagnostic radiology	6	40%	2
Psychology/psychiatry	9	10%	1
Lab services (covered at $0)	4	20%	1
Urgent care	2	25%	1
Lab services (covered for a fee)	1	10%	0.06
Total	$291		$69
Total paid for non-impactable services	$419		% deflected
Grand total paid	$711		9.7%

Low-risk cohort—members with at least one focus condition			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$42	50%	$21
Prescription drugs	119	15%	18
Specialist	42	30%	13
Emergency	13	50%	6
Inpatient care	41	10%	4
Diagnostic radiology	8	40%	3
Psychology/psychiatry	12	10%	1
Lab services (covered at $0)	5	20%	1
Urgent care	3	25%	1
Lab services (covered for a fee)	1	10%	0.09
Total	$285		$68
Total paid for non-impactable services	$436		% deflected
Grand total paid	$721		9.4%

Average-risk cohort—members with at least one focus condition			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$49	50%	$25
Prescription drugs	141	15%	21
Specialist	47	30%	14
Inpatient care	138	10%	14
Emergency	14	50%	7
Diagnostic radiology	10	40%	4
Lab services (covered at $0)	6	20%	1
Psychology/psychiatry	10	10%	1
Urgent care	3	25%	1
Lab services (covered for a fee)	1	10%	0.10
Total paid for impactable services	$419		$88
Total paid for non-impactable services	$554		% deflected
Grand total paid	$973		9.0%

High-risk cohort—members with at least one focus condition			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$51	50%	$26
Prescription drugs	145	15%	22
Inpatient care	178	10%	18
Specialist	56	30%	17
Emergency	18	50%	9
Diagnostic radiology	10	40%	4
Psychology/psychiatry	16	10%	2
Lab services (covered at $0)	6	20%	1
Urgent care	3	25%	1
Lab services (covered for a fee)	1	10%	0.11
Total	$484		$98
Total paid for non-impactable services	$759		% deflected
Grand total paid	$1,243		7.9%

Low-risk cohort—members with no focus conditions			
Service category	Paid PMPM	Deflection %	Deflected costs PMPM
Emergency	$31	50%	$15
PCP	12	50%	6
Specialist	9	30%	3
Prescription drugs	16	15%	2
Diagnostic radiology	1	40%	1
Urgent care	1	25%	0.37
Psychology/psychiatry	3	10%	0.32
Inpatient care	3	10%	0.32
Lab services (covered at $0)	1	20%	0.20
Lab services (covered for a fee)	0.14	10%	0.01
Total	$77		$28
Total paid for non-impactable services	$64		% deflected
Grand total paid	$142		19.8%

Average-risk cohort—members with no focus conditions			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
Emergency	$44	50%	$22
PCP	13	50%	6
Specialist	10	30%	3
Psychology/psychiatry	22	10%	2
Prescription drugs	13	15%	2
Inpatient care	11	10%	1
Diagnostic radiology	2	40%	1
Urgent care	2	25%	0.40
Lab services (covered at $0)	1	20%	0.19
Lab services (covered for a fee)	0.16	10%	0.02
Total paid for impactable services	$116		$38
Total paid for non-impactable services	$52		% deflected
Grand total paid	$168		22.4%

High-risk cohort—members with no focus conditions			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
Emergency	$52	50%	$26
PCP	12	50%	6
Specialist	9	30%	3
Prescription drugs	13	15%	2
Diagnostic radiology	1	40%	1
Urgent care	1	25%	0.37
Inpatient care	3	10%	0.28
Psychology/psychiatry	3	10%	0.27
Lab services (covered at $0)	1	20%	0.19
Lab services (covered for a fee)	0.15	10%	0.01
Total	$95		$38
Total paid for non-impactable services	$73		% deflected
Grand total paid	$168		22.8%

Appendix B
Gross deflected costs by deflection intensity

Low-risk cohort—low deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$26	40%	$11
Emergency	22	40%	9
Prescription drugs	66	10%	7
Specialist	25	20%	5
Inpatient care	21	5%	1
Diagnostic radiology	5	30%	1
Psychology/psychiatry	7	5%	0.37
Lab services (covered at $0)	3	15%	0.44
Urgent care	2	15%	0.33
Lab services (covered for a fee)	0.50	5%	0.02
Total	$178		$34
Total paid for non-impactable services	$245		% deflected
Grand total paid	$423		8.2%

Average-risk cohort—low deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$31	40%	$12
Emergency	29	40%	12
Prescription drugs	77	10%	8
Specialist	28	20%	6
Inpatient care	74	5%	4
Diagnostic radiology	6	30%	2
Psychology/psychiatry	16	5%	1
Lab services (covered at $0)	3	15%	1
Urgent care	2	15%	0.31
Lab services (covered for a fee)	1	5%	0.03
Total paid for impactable services	$268		$44
Total paid for non-impactable services	$303		% deflected
Grand total paid	$571		7.8%

High-risk cohort—low deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
Emergency	$35	40%	$14
PCP	32	40%	13
Prescription drugs	79	10%	8
Specialist	33	20%	7
Inpatient care	91	5%	5
Diagnostic radiology	6	30%	2
Psychology/psychiatry	9	5%	0.46
Lab services (covered at $0)	4	15%	1
Urgent care	2	15%	0.32
Lab services (covered for a fee)	1	5%	0.03
Total	$291		$49
Total paid for non-impactable services	$419		% deflected
Grand total paid	$711		6.9%

Low-risk cohort—high deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$26	60%	$16
Emergency	22	60%	13
Prescription drugs	66	20%	13
Specialist	25	40%	10
Inpatient care	21	15%	3
Diagnostic radiology	5	50%	2
Psychology/psychiatry	7	15%	1
Lab services (covered at $0)	3	25%	1
Urgent care	2	35%	1
Lab services (covered for a fee)	0.50	15%	0.07
Total	$178		$60
Total paid for non-impactable services	$245		% deflected
Grand total paid	$423		14.3%

Average-risk cohort—high deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
PCP	$31	60%	$19
Emergency	29	60%	17
Prescription drugs	77	20%	15
Specialist	28	40%	11
Inpatient care	74	15%	11
Diagnostic radiology	6	50%	3
Psychology/psychiatry	16	15%	2
Lab services (covered at $0)	3	25%	1
Urgent care	2	35%	1
Lab services (covered for a fee)	1	15%	0.08
Total paid for impactable services	$268		$81
Total paid for non-impactable services	$303		% deflected
Grand total paid	$571		14.2%

High-risk cohort—high deflection intensity			
Service category	**Paid PMPM**	**Deflection %**	**Deflected costs PMPM**
Emergency	$35	60%	$21
PCP	32	60%	19
Prescription drugs	79	20%	16
Specialist	33	40%	13
Inpatient care	91	15%	14
Diagnostic radiology	6	50%	3
Psychology/psychiatry	9	15%	1
Lab services (covered at $0)	4	25%	1
Urgent care	2	35%	1
Lab services (covered for a fee)	1	15%	0.10
Total	$291		$89
Total paid for non-impactable services	$419		% deflected
Grand total paid	$711		12.5%

Appendix C
Supporting literature

The brief literature review below is a survey of various studies that indicate varying levels of impacts related to initiatives not dissimilar to what HC2U undertakes with its DPCadvantage program. While these programs are not identical, they indicate that with focused actions on increasing timely access to high-quality primary care, various costs could decrease, including total costs, specialist costs, inpatient utilization, and ED utilization.

Category	#	Title	Link	Description
Total cost impacts	1	The effect of primary care visits on total patient care cost	https://pmc.ncbi.nlm.nih.gov/articles/PMC9793026	Increased units of primary care (i.e., increased access and utilization of primary care) reduces costs.
	2	2024 Book of Business Analysis, Premise Health	https://www.premisehealth.com/wp-content/uploads/2024/10/2024-Book-of-Business-Analysis-2.pdf	Use of primary care via employer-sponsored on-site primary care is associated with decreases in overall costs.
	3	A direct primary care medical home: The Qliance experience	https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0047	Increased utilization of primary care via a direct primary care program decreases overall cost. (Study may be subject to favorable selection bias).
	4	Direct primary care: Evaluating a new model of delivery and financing	https://www.soa.org/resources/research-reports/2020/direct-primary-care-eval-model	Use of direct primary care resulted in decreased costs on a risk adjusted basis before fees.
	5	Association between primary care and total cost: A study on New York state's commercial health insurance market	https://us.milliman.com/en/insight/primary-care-total-cost-new-york-commercial-health-insurance	Demonstrates association of increased primary care with lower overall costs.
Inpatient utilization	1	2024 Book of Business Analysis, Premise Health	https://www.premisehealth.com/wp-content/uploads/2024/10/2024-Book-of-Business-Analysis-2.pdf	
	2	Direct primary care: Evaluating a new model of delivery and financing	https://www.soa.org/resources/research-reports/2020/direct-primary-care-eval-model/	Use of direct primary care resulted in decreased costs on a risk adjusted basis before fees.
Specialist utilization	1	Electronic consultations to improve the primary care-specialty care interface for cardiology in the medically underserved	https://www.annfammed.org/content/14/2/133	Primary care's use of eConsults decreases specialist utilization and costs.
	2	Family physician-to-hospital specialist electronic consultation and access to hospital care	https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813916	
ED utilization	1	Direct primary care: Evaluating a new model of delivery and financing	https://www.soa.org/resources/research-reports/2020/direct-primary-care-eval-model/	Use of direct primary care resulted in decreased ED utilization.
	2	After-hours access to primary care practices linked with lower emergency department use and less unmet medical need	https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0494	Increasing access to primary care through extended office hours or 24/7 access to electronic consultations with PCP decreases ED utilization.

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