



Growth strategies that protect margin

Kevin Thilborger
Chief Manged Care and Revenue Strategy Officer

By the numbers

49

states represented in our client base

\$125M+

managed campaign spend in 2025

4B+

ads served

50+

past/current AMC clients

Largest

SEM buyer for healthcare providers

550+

Local and national media vendor relationships

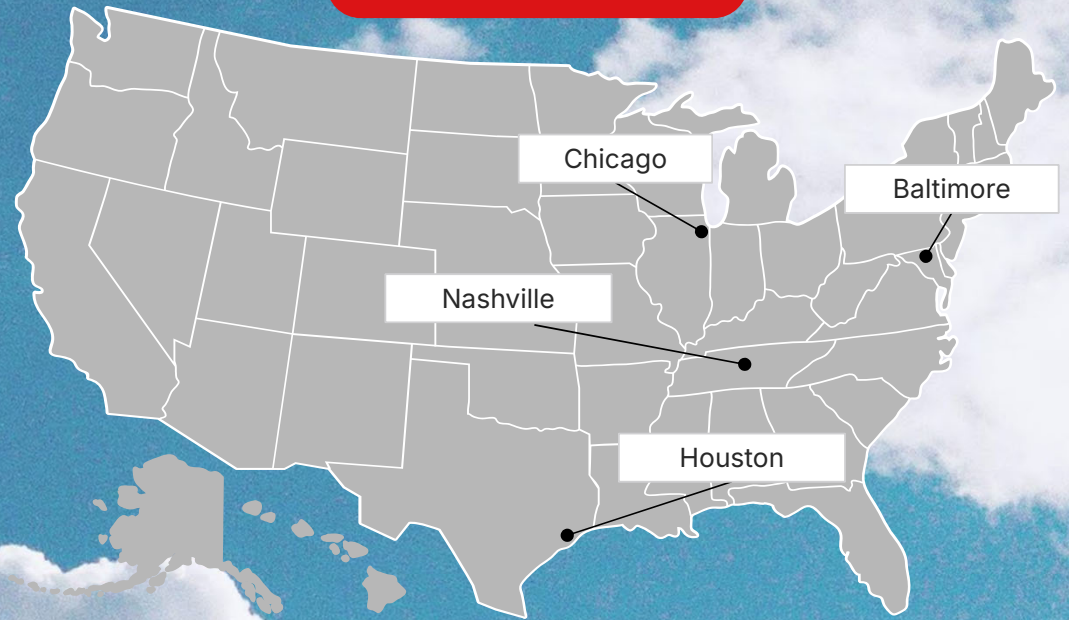
350+

creative awards

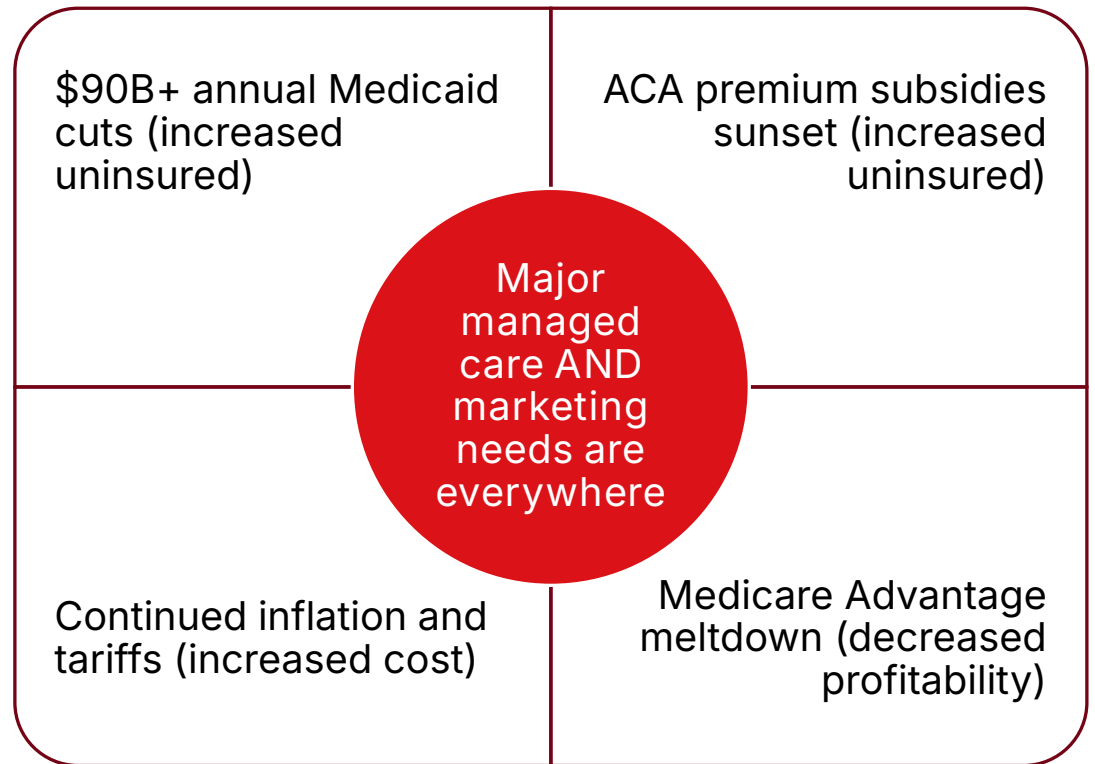
1,700+

websites developed

Unlock Health Offices

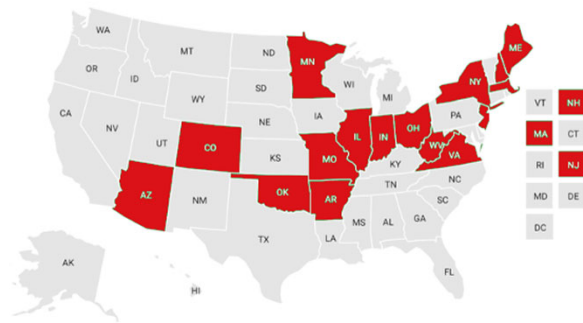


Looking forward to big changes in 2026?

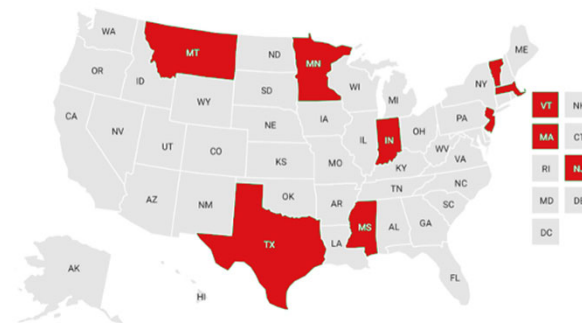


States move against hospitals

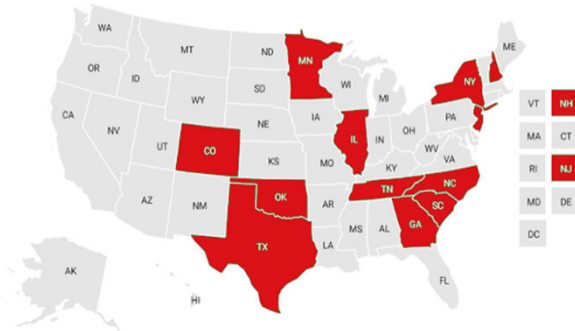
Price transparency
Yes (25 bills in 16 states)



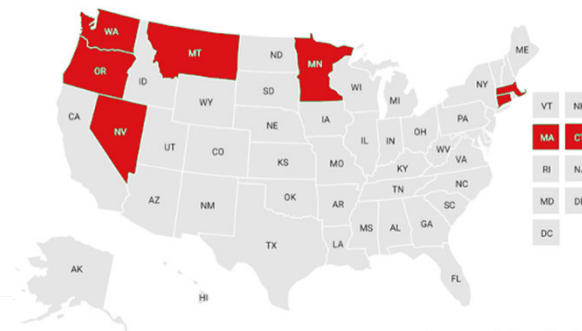
Reference rates
Yes (9 bills in 8 states)



Surprise billing
Yes (23 bills in 12 states)



Cost growth benchmarks
Yes (9 bills in 7 states)



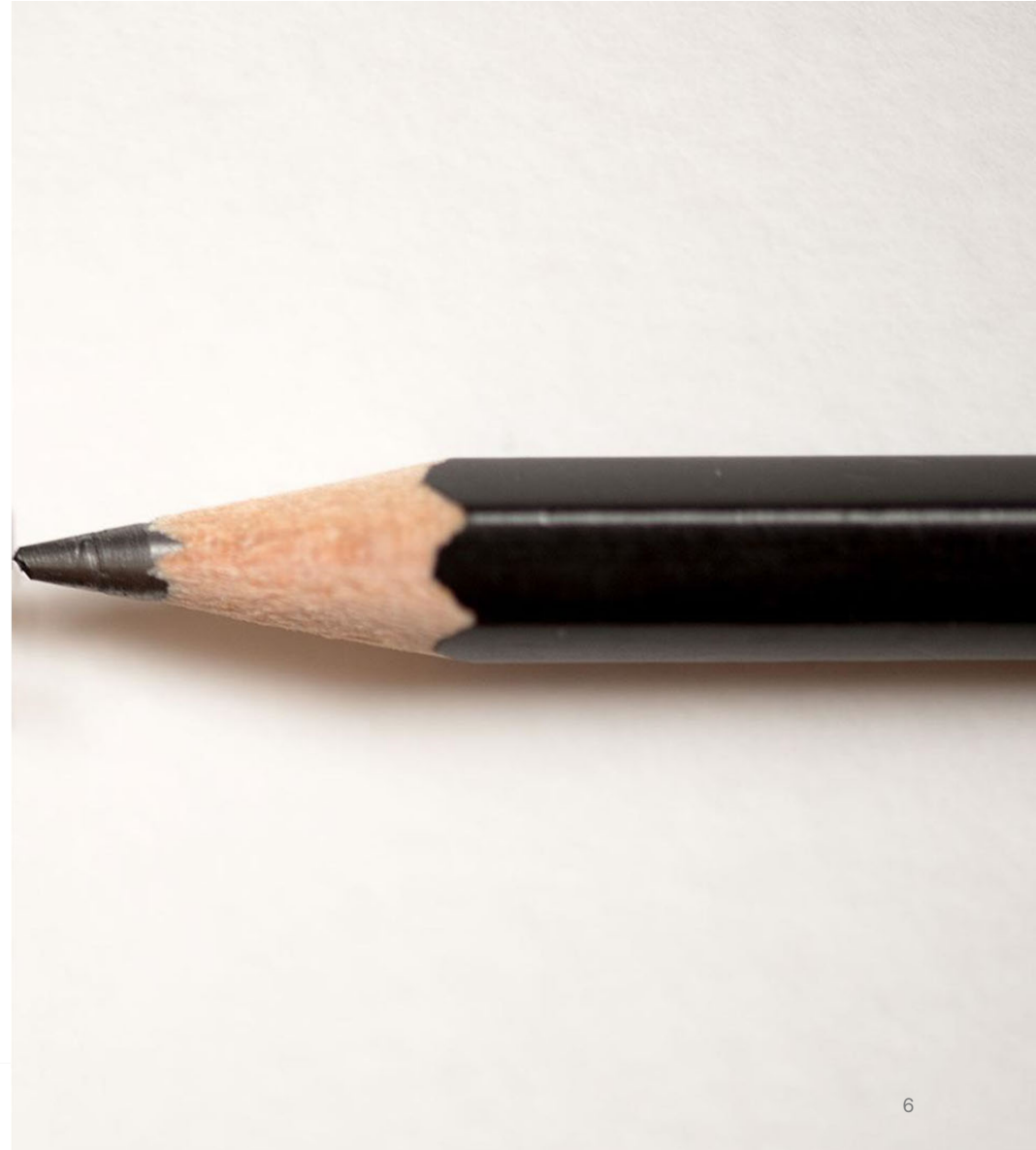
Hospitals: From heroes to zeroes

Hospitals have been under attack in D.C. (and in most states) for two years:

- Site-neutral payment cuts
- 340B payments slashed
- Facility fees cut
- Onerous price transparency requirements
- Tax exemptions threatened
- Surprise billing mandates that favor insurers and unfairly force prices down
- Medicare, Medicaid managed care policies that advantage insurers
- Medicare payments well below the inflationary costs of care
- Government anti-merger initiatives

Competing narratives: our side

A new analysis by the international accounting firm EY (also known as Ernst and Young) for the AHA shows that tax-exempt hospitals and health systems delivered \$11 in benefits to their communities for every dollar's worth of federal tax exemption in 2023, the most recent year for which comprehensive data is available.





Competing narratives: their side

- On average, nonprofit hospitals allocated 8.8% (~\$33M) of their expenses to various community benefits.
- Data shows that 24% of these hospitals received more in tax benefits than they spent on community benefits.
- On average, teaching hospitals allocated a higher percentage of total expenses to community benefits (9.2%) than non-teaching hospitals (8.6%).

Three distinct UHC responses to provider disputes

We are engaged in active discussions with Ascension Health Florida regarding our network relationship. Our top priority is to reach an agreement that is affordable for consumers and employers while ensuring continued, uninterrupted network access to the health system.

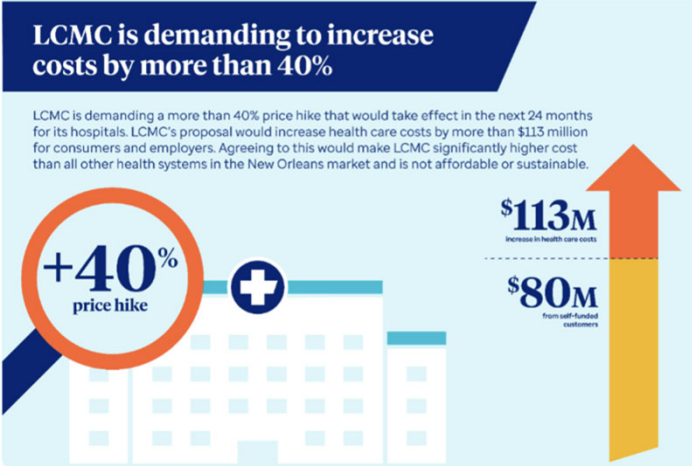
The truth about our negotiation with UF Health

We recognize many of you are rightfully concerned regarding UF Health's decision to leave our network as of Sept. 1. It was always our goal to reach an agreement that was affordable for Florida families and employers while ensuring continued access to the health system. Unfortunately, UF Health repeatedly sought a **30% price hike** over two years for our commercial plans, including a more than **23% rate increase in year one**, while also refusing to finalize the terms on which we agreed for our Medicaid plan.

As UF Health repeatedly pushes disinformation to the market, we believe facts matter and that you deserve the truth. As a result, we have created the following to help you understand the truth in response to the inaccuracies UF Health has communicated.

Myth No. 1: UnitedHealthcare insisted upon linking other products to the negotiation and abruptly imposing new conditions and changing language to items that had already been agreed upon.

False. For the past several weeks we proposed multiple times that we finalize our Medicaid contract given we had an agreement on terms. UF Health refused.



Scenario: Market pressures force providers to take a different contracting approach



Commercial rates are reasonable overall with pockets of improvement opportunities. Rate increases have not kept pace with cost increases. As a result, need a rate correction to achieve and sustain a healthy bottom line.



Payment policies often violate the terms of contracts and regulatory requirements. Client has historically taken a soft approach toward enforcing compliance but will be more aggressive in the future.



Competitors are out with Humana and United MA. What needs to be re-evaluated in light of yields below expectations.



Negotiations may result in having to terminate some contracts. Work groups created to address legal, legislative, public relations, and operational/clinical impacts as well as communication plans.

Tools to build the case: what informs our approach to payor contracting

Internal benchmarking

Identify gaps in reimbursement rates and yields across your own contracts to better understand how payors compare to one another within the organization

External benchmarking

Compare contractual rates against peer systems to justify market-aligned or higher reimbursement

Payor scorecards and KPIs

Use performance data (denials, delays, admin burden) to hold payors accountable and support rate increases

Consumer and market research

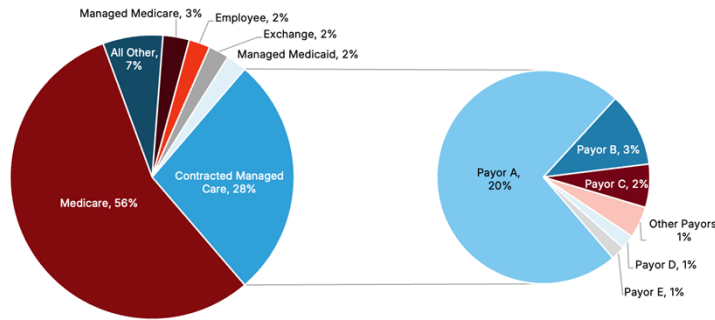
Leverage patient preference and market share data to show negotiating leverage and steer payor behavior

Communication plan and message platform

Coordinate messaging to stakeholders and the public to apply pressure and manage reputation during negotiations

Sample: internal benchmarking tools

Hospital net revenue summary



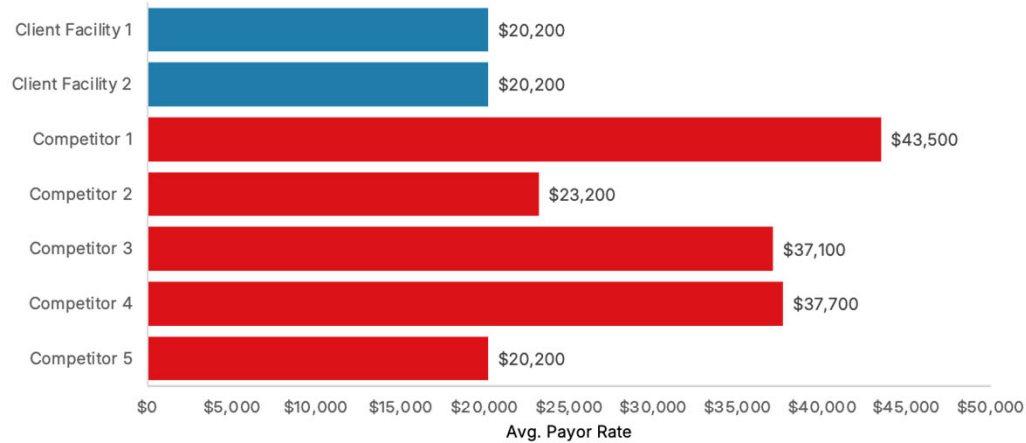
Hospital yield analysis

Financial Class	Net Revenue	IP Days	CMI ^[1]	CMI-Adjusted EPD ^[2]	CMI-Adj. EPD % of Medicare	OP Case Rate	ER Case Rate	Total % of Charges
Medicare	\$85.8M	15,386	1.6	\$1,922		\$510	\$825	26.8%
Managed Medicare	\$4.5M	1,308	1.7	\$1,268	66.0%	\$615	\$870	22.8%
Medicaid	\$0.2M	67	1.7	\$1,222	63.6%	\$220	\$480	14.8%
Managed Medicaid	\$3.6M	988	1.1	\$1,366	71.1%	\$295	\$300	13.0%
Contracted Managed Care	\$42.2M	2,234	1.4	\$3,616	188.2%	\$1,180	\$2,190	44.0%
Payor A	\$30.9M	1,897	1.3	\$3,550	184.7%	\$1,060	\$1,920	39.1%
Payor B	\$4.7M	126	1.2	\$6,742	350.9%	\$1,755	\$2,795	67.8%
Payor C	\$2.8M	108	1.3	\$4,136	215.2%	\$1,245	\$2,920	61.0%
Payor D ^[3]	\$0.9M	22	1.9	\$6,609	343.9%	\$1,680	\$4,930	89.8%
Payor E ^[3]	\$0.9M	25	1.0	\$2,300	119.7%	\$2,205	\$2,890	54.5%
Other Payors	\$2.0M	56	1.4	\$4,639	241.4%	\$2,035	\$3,850	69.6%
Exchange Plans	\$3.6M	482	1.5	\$2,595	135.1%	\$785	\$890	32.3%
Payor AA	\$2.2M	243	1.3	\$3,111	161.9%	\$730	\$905	32.2%
Payor BB	\$1.4M	239	2.0	\$1,953	101.6%	\$965	\$860	32.4%

- Growth opportunity
- Improvement opportunity

Sample: external benchmarking tools

IP: All DRGs - PPO



IP: Service Line Summary – PPO (Payor A)

Service Line	Client Facility 1	Client Facility 2	Competitor 1	Competitor 2	Competitor 3	Competitor 4	Competitor 5	Average Rate	Max Rate	Min Rate
Cardiac Medical	\$10,300	\$10,300	\$23,100	\$12,000	\$18,700	\$19,100	\$10,300	\$ 14,829	\$ 23,100	\$ 10,300
Cardiac Surg	\$40,600	\$40,600	\$92,800	\$48,900	\$71,700	\$73,900	\$40,600	\$ 58,443	\$ 92,800	\$ 40,600
IP Psych	\$13,000	\$13,000	\$10,100	\$12,200	\$18,400	\$9,700	\$13,000	\$ 12,771	\$ 18,400	\$ 9,700
Medical	\$11,500	\$11,500	\$25,600	\$13,800	\$22,000	\$22,600	\$11,500	\$ 16,929	\$ 25,600	\$ 11,500
Neonatal	\$27,800	\$27,800	\$4,700	\$4,000	\$42,400	\$2,200	\$27,800	\$ 19,529	\$ 42,400	\$ 2,200
Newborn	\$1,600	\$1,600	\$1,500	\$1,000	\$2,600	\$1,200	\$1,600	\$ 1,586	\$ 2,600	\$ 1,000
OB/GYN	\$9,700	\$9,700	\$14,700	\$7,000	\$16,300	\$11,300	\$9,700	\$ 11,200	\$ 16,300	\$ 7,000
Orthopedics	\$21,500	\$21,500	\$48,200	\$26,100	\$40,200	\$42,100	\$21,500	\$ 31,586	\$ 48,200	\$ 21,500
Rehab	\$10,900	\$10,900	\$20,600	\$12,700	\$18,300	\$17,200	\$10,900	\$ 14,500	\$ 20,600	\$ 10,900
Surgical	\$23,100	\$23,100	\$52,800	\$27,900	\$44,700	\$46,500	\$23,100	\$ 34,457	\$ 52,800	\$ 23,100

Benchmarking results

Internal benchmarking insights

- Internal yields lower than other commercial payors
- Yields for Medicare Advantage are far below expected. United MA profits higher than ever while denying, delaying, and not addressing open issues
- Physicians have not had increases in years on certain products
- Physician paperwork is up overall despite national rhetoric from United.

External benchmarking insights

Based on available transparency data, overall services are:

- Below the market average overall
- In a three state area, the bargain amongst AMCs

Payor scorecards and KPIs

SAMPLE	Payment to Charge Ratio		CMI-Adj. EPD % of Medicare			Initial Denial Rate (#)		Initial Denial Overturn Rate (#)		Appeal Overturn Rate (#)		Avg Days to Respond		Avg Days to Pay		Patient Portion % of Total Exp Reimbursement		% of Patient Portion Collected	
Medicare	16.3%					9.8%	81.9%	79.1%			16.8	17.5			11.4%	4.9%			
Commercial	44.0%		85%			188.2%	77.9%	38.0%			14.4	15.4			4.7%	67.6%			
Payor A	39.1%		82%			184.7%	73.6%	44.5%			21.3	21.6			4.2%	55.8%			
Payor B	67.8%		83%			350.9%	78.4%	24.4%			9.4	10.6			4.1%	82.6%			
Payor C	61.0%		78%			215.2%	80.8%	35.6%			12.1	13.6			6.3%	58.5%			
Payor D	89.8%		98%			343.9%	82.3%	50.9%			12.3	13.9			4.2%	93.3%			
Payor E	54.5%		59%			119.7%	80.0%	NA			21.9	22.1			0.4%	450.9%			
Payor F	69.6%		64%			241.4%	73.6%	87.5%			8.3	10.3			6.4%	29.4%			

Results: Key insights from KPI summary

- UHC denies payment for care 40% more than other national insurance carriers
 - We overturn 97% of these denials
 - We employ 236 people full time to appeal *all* denials from payors
- UHC has been 57% slower to pay claims than other payors
- UHC takes over 60 days to respond to claims they deny

Consumer and market research

Key findings

78% of insured adults report a favorable impression of provider, including 77% favorable among UHC beneficiaries.

Top opposing messages: the increase a provider is looking for is too high and insurance companies are protecting affordable access

Strongest statements: 1) a critical part of the healthcare ecosystem, and 2) capabilities extend beyond other states

76% say they would side with provider over a generic insurance company (24%) in a financial dispute

When UHC is named, they choose provider 88%-12% (71% of UHC members)



Favorable impression:
UHC 27%

Leverage points with UHC

Community importance

Provider provides essential access to inpatient, outpatient, and physician services. Provider is the critical backstop provider for many in and out of state health systems that are receiving higher payments

Network adequacy

If provider were to go out of network, it will impact the health plan's ability to sell business.

National industry dynamics

Hospitals are experiencing severe margin pressures while health plan profits have surged.

Quality performance

Despite financial and capacity pressure, provider continues to outperform on quality.

Payment rates

Provider payment rates as a high-end academic health system should target the 75th - 90th percentile.

Payor policies

Payor policies are increasingly further eroding health system revenue.



Negotiation communications

We aren't focused on how to not to lose, but how we win in brand and revenue.

The campaign helps audiences understand that your ability to deliver care relies on equitable contracts and fair payment from insurers. Create a *bespoke message platform specific to the negotiation*. The messaging then escalates through the phasing as we approach the termination date.

Phase 1

Educate audiences about your value and what is at stake if you cannot get fair payments from insurers.

Phase 2

Create advocacy among key audiences, encouraging patients to advocate for themselves/their health and continued access to their physicians.

Phase 3

Prepare to be potentially out of network for some period of time and minimize impact (patient retention as feasible, continuity of care).

Phase 4

Notify key audiences of OON status. Continue following up once per month until a resolution is reached.

Key message

Brilliance – Duke Health is irreplaceable in your network



Duke Health has medicine's finest minds. Will you have access to them?

You expect UnitedHealthcare to allow choices – that includes Duke Health's unrivaled care and physicians. UnitedHealthcare may soon limit your choices and take away access to Duke Health and the trusted experts that so many families depend on, day and night. From bumps and bruises to complex care only available at Duke Health, you deserve to have access to the highest quality of care, even as we advocate to keep Duke Health in-network with UnitedHealthcare.

To learn more and make your voice heard visit DukeHealthAccessUnited.org



Key message

Committed to You — Duke Health always acts in your best interest, United doesn't



At Duke Health, all we do is care – every day, all day. Does UnitedHealthcare?


You expect UnitedHealthcare to allow choices – that includes Duke Health's unrivaled care and physicians. UnitedHealthcare may soon limit your choices and take away access to Duke Health and the trusted experts that so many families depend on, day and night. From bumps and bruises to complex care only available at Duke Health, you deserve to have access to the highest quality of care, even as we advocate to keep Duke Health in-network with UnitedHealthcare.

To learn more and make your voice heard visit DukeHealthAccessUnited.org



Key message


United? We don't think so — United is serving their own interests, not their patients



"United" may cause your healthcare to fall apart.

You expect UnitedHealthcare to allow choices – that includes Duke Health's unrivaled care and physicians. UnitedHealthcare may soon limit your choices and take away access to Duke Health and the trusted experts that so many families depend on, day and night. From bumps and bruises to complex care only available at Duke Health, you deserve to have access to the highest quality of care, even as we advocate to keep Duke Health in-network with UnitedHealthcare.

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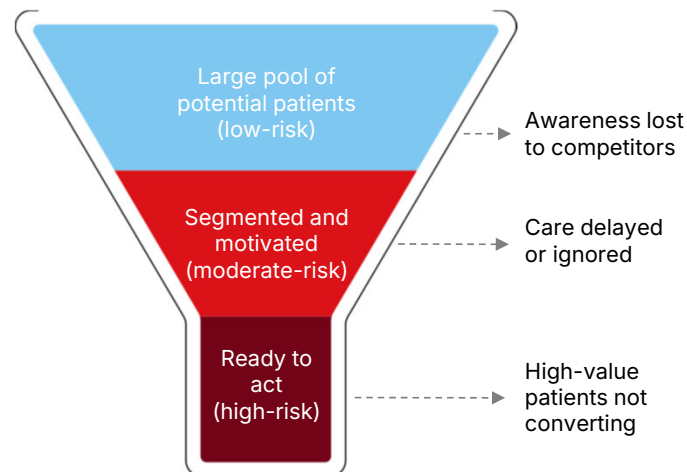
Out of network disruption: Volume drops, demand doesn't

What happens OON

- Loss of in-network patient flow
- Disruption of referral patterns
- Competitors absorb "default" volume

The hidden reality

- Loss of in-network patient flow
- Disruption of referral patterns
- Competitors absorb "default" volume



The opportunity



Demand isn't the problem — lack of connection and guidance is.

HRAs close that gap.

HRAs rebuild volume and strengthen your negotiating position

A proven model to recover patient volume and create leverage in negotiations

Top of funnel (low-risk)

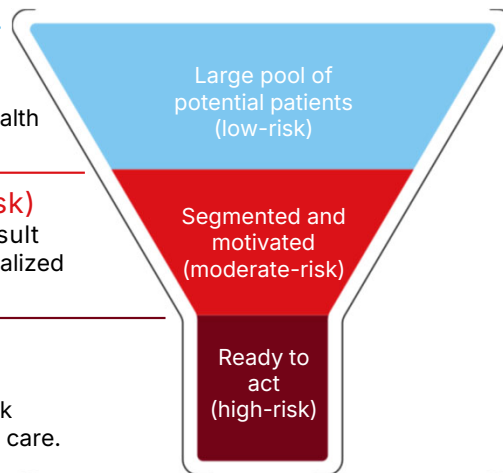
Engage, educate, nurture
Attract broad audiences and gather health insights to identify potential patients.

Middle of funnel (moderate-risk)

Segment, personalize, move to consult
Use risk stratification to deliver personalized messages and drive consult intent.

Bottom of funnel (high-risk)

Refer, convert, coordinate care
High-intent patients take action — book appointments and receive coordinated care.



Full-stack capability

- Strategy and segmentation
- Creative and content
- CRM integration
- Performance analytics

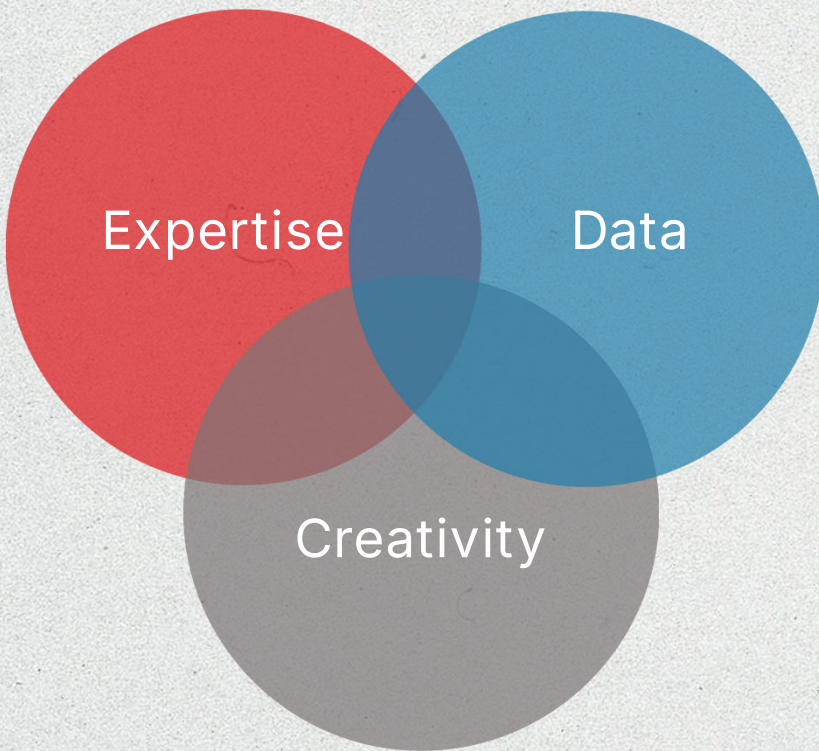
Why it strengthens your negotiating position

- ✓ Proves ability to generate independent patient demand
- ✓ Reduces reliance on payor networks
- ✓ Recovers high-value service line volume
- ✓ Provides data-driven proof points to support fair reimbursement
- ✓ Demonstrates you can attract, engage, and convert the right patients — at scale



HRAs turn disruption into opportunity — recover volume faster and negotiate from a position of strength.

About Unlock



Introducing Unlock Health

Our model combines healthcare expertise, rich consumer and clinical data sets, and bold creativity to help you:

1. Know where to spend your next marketing dollar
2. Drive more qualified patients into your service lines
3. Build your brand locally, regionally, and nationally
4. Attract and retain talent required to support market growth

Our differentiators



Built the standard

Our leadership defined the negotiation communication industry and remains actively involved in client engagements today.



Strategy built together, informed by experience

We partner with clients to build the negotiation strategy, applying decades of experience to inform decisions and support execution end to end.

Proven success in public negotiation campaigns

We have led high-profile public negotiation campaigns for the past 20 years.



Negotiation communications partner for multiple top-tier AMCs

We have supported prominent AMCs in public negotiations, aligning communications with the unique demands of AMC environments.



Fully integrated expertise

The only firm with Strategic Communications and Managed Care Consulting expertise in a fully integrated offering.

Known by the company we keep





Thank you

Kevin Thilborger

Kevin.thilborger@unlockhealthnow.com | 404.784.5545 mobile

