Signia Podcast Series: Successfully Navigating the Shift in Third-Party Reimbursements Post Covid-19

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Presenter: Brian Taylor, AuD; Patty Greene, MA

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Brian Taylor: Welcome everybody. This is Brian Taylor at Signia, and today we have a special edition of our Business of Blended Care podcast series. These days it's certainly not business as usual and our topic for this afternoon's recording, this one hour session is Successfully Navigating the Shifts in Third Party Reimbursements Post-COVID-19 with our special guest today, Patty Greene of TruHearing. In today's podcast, we will use the term blended care a little differently. You might recall that in this series, we usually refer to blended care as a combination of in-person and remote hearing care services. But today we're going to refer to blended care a little differently. Today we'll refer to it as a mix of private pay and third party insurance business in an audiology practice.

In contrast to many European countries, Australia and New Zealand, US hearing aid wearers have historically had very limited government or private insurance coverage for hearing aid purchases. The only exception to this in the US is the VA, which comprises about 20% of the total hearing aid market. The lack of insurance coverage has been identified as a contributing factor to the US market's low level of hearing aid uptake, which is estimated to be between 25 and 30% of the hearing impaired population while other similarly developed countries around the world have a market uptake ranging from 35 to 45%. In recent years, the number of insurance plans offering some level of coverage for hearing aids has grown a lot. It is estimated that today about 10% of US hearing aid private market purchases are at least partly funded by insurance. And that number is expected to grow substantially over the next few years.

Over the last five or so years, many Medicare Advantage programs have introduced hearing healthcare benefits to new Medicare Advantage enrollees. Many of these plans enable their enrollees to purchase a pair of hearing aids at a significantly reduced rate compared to those that have, for those that have to pay completely out of pocket in the private market. For example, many Medicare Advantage programs with a hearing aid benefit enable the enrollee to purchase a premium hearing aid for a copay of between 700 and $1,000, and you can compare that to an average out of pocket cost of about $2,000 per hearing aid in the US private market. Let's get to our guest. So here to help us unpack the dynamics of the third party insurance market and hearing aid benefits is Patty Greene. Patty is an audiologist and she's the director of provider engagement for TruHearing. I'd like to welcome Patty to the podcast.

Patty Greene: Thank you, Brian. I really appreciate the invitation today. And I'm looking forward to speaking with you about this topic.

Brian Taylor: Yeah, we're really glad to have you here. So after this long winded introduction that I gave to the topic, let me go ahead and have you tell us a little bit about yourself and TruHearing.

Patty Greene: Great. I'm an audiologist, as you mentioned already, I've been in practice as an audiologist well, say for 30 years. I started out in private practice and then I worked for two of the leading hearing aid manufacturers for many years, the majority of my career in a variety of positions. I was in sales, training, and marketing. And then in 2015, I joined TruHearing. And primarily because I saw a really big shift happening in our industry and I wanted to be part of that change. And also because TruHearing wanted to have audiologists on staff primarily to have provider input into what TruHearing does. To move on to TruHearing, TruHearing was founded in 2004. The mission is to improve lives by making healthcare more affordable.

And we know that about 73% of adults in the US go untreated with their hearing loss. So our goal at TruHearing is to reach some of those 73% who have untreated hearing loss, but maintaining provider care.

Brian Taylor: Well, that's good to know, Patty, thanks for keeping us up to date on what TruHearing's mission's about. I think a new or a good place to start would be for you to tell us about Medicare Advantage and third party reimbursement. What are Medicare Advantage and third party reimbursement and how long have they been around?

Patty Greene: Sure. Medicare Advantage has been around since 1997. Although it was originally referred to as Medicare Choice, in 2003, the name changed to Medicare Advantage. And that's really offered to consumers who are age 65+. Once you turn 65, you have two paths you can take when you choose your health insurance. You can enroll in traditional Medicare, which is administered by the federal government, or you can elect to enroll in a Medicare Advantage plan, which is privatized insurance. But you can't enroll in both. And I'd like to just take a moment to talk about traditional Medicare versus Medicare Advantage because I see these terms used interchangeably and there are significant differences between the two. And if we're going to lay a foundation about Medicare

Advantage and third party, and hearing aid benefits, we really need to have an understanding of the two.

Traditional Medicare covers hospital stays, hospice, skilled nursing under what they call part A. Part B is more medical care. So your doctor's visits and outpatient care. As you can see, traditional Medicare may leave gaps in a person's healthcare coverage because it doesn't cover items such as prescription drugs, vision, dental, or hearing aids. So the Medicare beneficiary would have to buy additional insurance called Medigap or Medicare supplemental insurance. That's why we're seeing a growth in Medicare Advantage. Medicare Advantage plans such as Blue Cross Blue Shield or Humana, for example, they all have to offer the same coverage as traditional Medicare, but they can elect to offer additional benefits such as maybe a fitness benefit. You might have heard of SilverSneakers or transportation, vision, dental. And of course, what we're here to talk about today, hearing aid benefits.

These additional benefits are attractive to a growing number of Medicare beneficiaries, which is why we're seeing movement from enrolling in traditional Medicare over to Medicare Advantage. The second part of your question, Brian, was to ask about third party reimbursements and how they work. In simplistic terms, third party reimbursements are payment for services by an entity other than the patient. So for today's discussion, since we're talking about managed care hearing aid benefits administered by a third party, in this example, the provider payment doesn't come from the patient or the health plan. It comes from the third party company administering the benefit. I'll use TruHearing as an example. Humana is one of our large health plans that contracts with TruHearing. And they contract with TruHearing to administer their hearing benefits.

TruHearing then contracts with a provider to fit the Humana members with hearing aids and in turn pays the provider a fee for those fittings. That's a third party reimbursement. So a side note, and since we're talking about insurance plans and third parties is that even though we're primarily talking about Medicare Advantage plans, TruHearing and other similar companies like us also partner with commercial insurance plans. So it's insurance for those under 65. So it's my insurance, your insurance, and our listeners' insurance predominantly. In each of these cases, the fees paid to the hearing care providers under those plans are also third party reimbursements because the patient's not paying.

Brian Taylor: Got it. Thank you for the overview of Medicare Advantage and third party reimbursements. I'm sure our listeners will appreciate kind of a review of that terminology and what they mean. I want to go back, I mentioned in my introduction that Medicare Advantage memberships have really grown over the past few years. Can you tell our listeners why we've seen such growth in those programs?

Patty Greene: Yes. I'm glad you asked that because this a really important topic for providers to understand, because as we've seen, especially over the last five years, I would say specifically, it's played an increasingly important role for hearing care providers and it's going to continue to do so. So this is a topic that I would urge providers to learn as much about as possible. And I hope today's discussion really gives a lot of good information because I always think information and knowledge is power and helps you make good decisions. First I'd like to talk about how much growth the Medicare Advantage space in general has seen. And then we can discuss the growth of hearing aid benefits, because the two are intertwined and it helps to have an understanding of the growth of Medicare Advantage in general first.

So I'd like to share some statistics from the Kaiser Family Foundation about Medicare Advantage growth. For the 2020 plan year, there were 3,148 Medicare Advantage plans available for individual enrollment national wide or nationwide. That's an increase of 414 plans over 2019. In 2019, 34% of all Medicare beneficiaries, so that's 22 million beneficiaries were enrolled in a Medicare Advantage plan. That's a lot of Medicare-

Brian Taylor: [inaudible 00:10:20].

Patty Greene: ... beneficiaries. The Congressional Budget Office projects of the share of beneficiaries enrolled in a Medicare Advantage plan is going to rise to about 47% in the next nine years. So by 2029. So it's going to continue to see some significant growth, but now we have a lot of Medicare beneficiaries enrolled, yet when we look at where the concentration is of those 22 million beneficiaries, it's highly concentrated amongst a small number of companies or firms. The average Medicare beneficiary is able to choose from plans offered by just those seven firms in 2020. So to elaborate on this, to make more concrete examples here, UnitedHealthcare and Humana are the largest and together they account for 44% of all Medicare Advantage enrollees nationwide. And they both offer hearing aid benefits.

Blue Cross Blue Shield affiliates, including Anthem Blue Cross Blue Shield plans accounted for another 15% of enrollment in 2019. They also have hearing aid benefits. Another four firms, CVS, which purchased Aetna, Kaiser Permanente, WellCare, and Cigna accounted for another 22% of enrollment in 2019. So you see where I'm going here. So 81% of Medicare Advantage enrollees are enrolled in a plan under those seven firms. In 2020, the average Medicare beneficiary had access to 28 plans. So when they're choosing their insurance, they have access on average to 28 plans. Some of them-

Brian Taylor: [crosstalk 00:12:11] plans.

Patty Greene: That's a lot of plans and some of them could be 40 or 60 Medicare Advantage plans. That's a lot of choice. So first glance, even though we're saying less than 10 Medicare Advantage and other similar third party insurance companies offer a hearing aid benefit, that may not seem significant, but when we consider the number of Medicare beneficiaries enrolled in a plan offered by these companies, this is huge for hearing care providers and they really need to be aware of this. Because like I mentioned, all of these companies just a moment ago, they all offer hearing aid benefits. And this is growing.

Brian Taylor: Right. So in other words, Medicare beneficiaries have a whole lot of choices when it comes to their hearing or their health insurance plan. So if that's the case, why has there been so much growth in hearing aid coverage?

Patty Greene: That's correct. There's a lot of choices I just mentioned. Medicare beneficiaries, these consumers have a lot of influence and this growth we're seeing, especially with regards to Medicare Advantage plans offering hearing aids as a reimbursable expense, the growth we're seeing is because they're doing this to address consumer demand for lower out of pocket costs. So let's think about this. You have an older consumer who has a hearing loss and what do they do? They think of hearing care as a healthcare issue, right? Just like I think of hearing care as a healthcare issue. I know all of our listeners do and you do as well, Brian, it's a healthcare issue.

Brian Taylor: Sure. Right.

Patty Greene: And if we look at Market Track Nine, more consumers regard hearing aids as a medical device. So if it's a healthcare issue and

hearing aids are a medical device, it's natural that they'd expect their health insurance to offer some level of hearing aid benefit. So to further understand why plans are offering hearing aid coverage, it's not just to meet consumer demand, but it's really to understand... We first have to understand the health plan landscape because it's very competitive. If you look at the health plan landscape, especially for health plans wishing to attract those aged 65+, and just a moment ago I said some of them have access to 60 plans or more, so it's very competitive, just like our field, right?

So if they're wishing to attract those aged 65+ and 10,000 people every day turn 65. And if we look at the baby boomers, and of course in our industry, we've spent years talking about the baby boomers, right? I know we've both done speaking engagements about baby boomers, but all baby boomers will be 65 by the year 2030. So insurance companies just like audiologists are competing to attract them. This makes consumers a very influential group. So simply put, if one plan doesn't offer what that consumer's looking for, that Medicare beneficiary is seeking, they can simply move on and choose another plan that does. So it puts-

Brian Taylor: [crosstalk 00:15:27].

Patty Greene: Yeah. So it puts the health plans under increased pressure to provide high value and high quality benefits, but they need to keep their costs low. And we know, everyone is fully aware of how high the cost of healthcare is in this country. Health plans are very competitive. They're trying to find the high value, high quality benefits, but still manage costs. They have to manage their own costs and they want to keep their members' out of pocket expenses low because of the competition. So when we look at the health plans, they have limited budgets. So they have to be very careful about what benefits they offer. Do they choose to offer vision? Is that going to attract more membership? Or a dental benefit, fitness, transportation, meals. And now, as we're seeing, do they offer hearing aids?

Which of these benefits should they offer on their limited budget and which is going to provide the most value to attract and retain members while controlling costs for the plan and for the member? And they look at hearing aids as a shiny object because the more and more plans are electing to offer them, because it's a valued benefit that attracts the members to those Medicare Advantage plans, because those are the 65+ group. And so the more

members they can attract, the better quality benefits they can offer just simply through economies of scale.

Brian Taylor: Hearing aid allowances, I would assume are an attractive benefit for a plan to offer.

Patty Greene: That's an interesting topic because on the surface, I know as a provider myself, I loved it when a patient came in with an allowance. So I thought, okay, I'm going to be able to help this patient. They've got some financial support from their plan. It's going to save them money. They're more apt to buy. Allowances are great. But on the surface, even though they seem like a great solution to both the plan and its members, because it appears to save both the plan and the member money, it doesn't because while the allowances effectively control the health plan's cost exposure, it doesn't address the underlying cost of the hearing aid. So it can still leave their members with significant out of pocket costs. And remember, members are pushing their plans for more benefits and more cost effective or more effective cost controls.

They're paying for their health insurance. They want to get the most out of it, and they want their health insurance to cover everything. So how often have you, Brian, as a clinician, how often have you heard a patient say, "Well, I thought my insurance covered my aids?" Because-

Brian Taylor: Yeah. All the time.

Patty Greene: Right. They had a $500 allowance and they thought, well, I have insurance. And that happens a lot. So they're disappointed when they find out, well, $500, yeah. That's great, except it's still going to leave you a lot of out of pocket for those top of the line hearing aids.

Brian Taylor: Right.

Patty Greene: Yeah. So now rethink that allowance. If they have a $500 allowance, one of three things are going to happen. So either the patient's going to leave the provider's office without purchasing hearing aids, because they did expect their insurance to fully cover their aids. Because when they called, they said, yes, you have insurance. And they just thought $500 would cover it. Or they're going to leave paying some of the costs out of pocket, which isn't going to make that health plan member happy. Or for those consumers who are aware of the cost of hearing aids, because

they've done their research online in advance, or they've talked to their friends and family, they may not even step into a provider's office because they already know that $500 is not going to go very far. So back to allowances, what appeared to be a quality benefit really isn't.

Brian Taylor: Yeah. I can see how the risk from both the patient and provider standpoint about allowances. I wish I'd have known that 10 years ago, Patty. So thanks for clarifying what a hearing aid allowance really, what that entails. But as far as health plans are concerned, back to just the general healthcare plan, why would they want to offer a hearing aid benefit, since allowances are a little bit sketchy, how do they offer a benefit to attract members? How are they handling that?

Patty Greene: They want to offer a hearing aid benefit as we know because they're competitive, they have a very competitive world and they need to attract more members to bring in more money, to get more federal money as well to offer those varied benefits. So they want to, but they don't know how to do it. And so we're seeing a growth in this area because there is a solution that's attractive to the health plan and the members, and that's going to meet the needs of the plans and the members by partnering with a third party company, like a TruHearing. And so I do want to mention, kind of put the elephant in the room here. Over the years, I've talked to a lot of providers and the question I get since I've worked from TruHearing is, "Patty, I don't understand why does a TruHearing exist? Why do third parties exist? Why doesn't the helpline just partner with me, the provider? I'm the one providing the care. Why don't they just do that directly?"

I'd like to talk about that because that is a big topic for providers and I hope we can help them understand why third parties exist and why they'll continue to exist. Partnering with a third party, like a TruHearing is attractive for a health plan because it allows the plan to control costs for themselves and their members. And there's a lot of things that the third party company does for the health plan to address these costs. And primarily it's done by the plan outsources the complexity of the administrative tasks of that benefit to the third party. So that includes things like managing the provider network. So TruHearing, for example, manages the provider network. We handle the contracting of providers, credentialing providers, as well as making sure that there's adequate network coverage so that the health plan members have easy access to care.

We handle the benefit administration, which is of significant value to both providers and the health plan, because it creates a single source of contact for the plan. So the plan contacts with that third party, and they don't have to contract with individual providers and sometimes thousands of providers, you look how big Humana is or Blue Cross Blue Shield and all of those individual contacts is very cumbersome and requires a lot of resources, as opposed to simply contracting with a third party. The third party also negotiates hearing aid pricing and provides product expertise. Something a health plan has no knowledge and resources to do. A third party could handle marketing and education to the plan's membership. So the third party is handling a lot for the health plan and making it very easy.

In addition to that, in many cases, the third party handles claim submissions. So processing the claims for hearing exams, for example, or the hearing aids, which is also a plus for the providers because the providers in these instances don't have to process claims and wait for payment. They're going to save themselves and their staff time and money in those instances. So all of these tasks I've mentioned, managing the network, the benefit administration, negotiating the hearing aid pricing, the marketing and education, and the claim submission, those are all required to effectively administer the hearing aid benefit. But it's not something a plan has the resources to do or the knowledge, because keep in mind, hearing aids are very small, more specialized healthcare discipline for the plan.

Brian Taylor: Right.

Patty Greene: So that's why they're looking to third parties. But also if we think about how a health plan operates, from the health plan's perspective, remember they're managed care. So by definition, managed care is a healthcare delivery system organized to manage cost utilization and quality. So thinking of cost utilization and quality, in a health insurance setting, this consists of restrictions. There are restrictions around what providers you can see, what products and services are covered, and the amount of financial contribution from your plan. So it's not about your insurance paying for everything. We all know that. When we go use our insurance, we know the insurance doesn't pay for everything all the time. There are restrictions in place. And again, those are to manage costs, utilization, and quality.

So that's what we're seeing with regards to hearing aid benefits. So with hearing aid benefits, they're going to place restrictions around maybe what provider you can see. For example, our health plan partners, for many of our plans, you have to be in network with TruHearing. So they're putting restrictions around that. They might put restrictions on what hearing aids are available to their members and how much they're contributing financially. So there's restrictions to control that cost, utilization, and quality. Another example, and I like to give this one, because this one hit home for me years ago when I needed some dental services done. And so think of your insurance. Do you have dental insurance, Brian?

Brian Taylor: I do.

Patty Greene: I do too. If you have dental insurance, it may provide coverage for a crown, but maybe not a dental implant as in the case of my insurance. And they may require you to be seen by an in-network dentist. And then after all that, maybe they only cover a portion of the crown. So my example, they covered 50%. So I thought, well, gosh, I have some, but I still have out of pocket, but this is an example of managed care in the dental world. So in dental insurances, managing costs, utilization, and quality by placing restrictions. And this is something health plans have struggled with with regards to hearing aids.

They've struggled to control costs for hearing aids, which is why the majority have not offered hearing aid benefits until third party partnerships came along because third party partnerships offer them a way to stay competitive with their plans and their world and offer a valued benefit by offering some type of hearing aid coverage so they can attract membership.

Brian Taylor: Well, that's really good to know, Patty. I can see how a company like TruHearing helps a provider manage the complexities of the entire healthcare system. So thanks for kind of demystifying that. I guess another question I had is, how many of these Medicare Advantage companies offer a hearing aid benefit and how do these benefits differ from another?

Patty Greene: Sure. As we discussed earlier, hearing aid benefits are concentrated amongst fewer than 10 companies. However, under each of these companies, they have many individual plans which may offer a benefit. Like if I have Blue Cross Blue Shield insurance, I may have five, 10 plans, individual plans under Blue Cross Blue Shield to choose from. So when we look at Medicare Advantage,

I'm not quite ready for Medicare Advantage yet, just to clarify. In 2015, the number of individual Medicare Advantage enrollees enrolled in a plan with a hearing aid benefit was 47%. This grew significantly in 2017 to 65% and to 73% in 2018, and it continues to grow. So year over year, the number of Medicare Advantage enrollees choosing a plan that offers a hearing aid benefit is growing significantly.

And so for how these benefits differ, it's first important to understand that the insurance company decides which benefits it's going to offer its members under each plan. So each plan is going to vary just like when we choose our insurance, we may have three different plans with different copays and different max out of pockets and values to us and maximum out of pocket as well to choose from. There are many different plans to choose from. If we look at the differences amongst the different companies, it could be, do they partner with a third party company or not? And how does that third party company operate differently with the provider network? What are those requirements? What, if any, is the financial contribution from the plan to the member? Not all contribute financially to their member.

What hearing aids are available to that member and what additional offerings does the member receive under that plan with regards to batteries, provider visits, trial time, et cetera? They're all determined by the individual plan. And so it varies.

Brian Taylor: Right. Well, that's a good explanation of some of the intricacies of these different plans and the benefits and the packages within each benefit that they offer. I wanted to shift gears a little bit, Patty, if that's okay, and talk about older adults.

Patty Greene: Sure.

Brian Taylor: Let's talk a little bit about older adults who are members of these programs. I'd be interested in, how many of the have hearing loss? What do they look like? And what are these Medicare Advantage programs, what do they look like?

Patty Greene: Sure. First, remember Medicare Advantage plans are for those aged 65+. And according to the National Institutes of Health, approximately one in three people between the ages of 65 and 74 have a hearing loss and nearly half of those 75 and older have hearing loss. So that's a lot of people, that's many people that are enrolling in those Medicare Advantage plans. Because as we

discussed earlier, 22 million Medicare beneficiaries or 34% are enrolled in a Medicare Advantage plan. And this is a growing segment. So this is going to continue to grow year over year again, because traditional Medicare isn't offering consumers all the healthcare benefits that they want. And so rather than purchase supplemental dental and supplemental vision hearing, et cetera, they're choosing a Medicare Advantage plan that might already bundle all of that into their current plan. And they like that.

So consumers like it because it's bundled, but they also choose Medicare Advantage plans because if they have a hearing loss and they want hearing aids, as I just mentioned, traditional Medicare doesn't provide any coverage. So the Medicare Advantage programs is attractive to them because these programs and other similar managed care programs with an insurance benefit save on average more than 50% on hearing aids compared to those who pay out of pocket without any insurance benefit. And consumers, because they're already paying a premium every month for their insurance, they want to use it just like you and I want to use our insurance. That's the first thing we go to when we have a health issue is do I have insurance and where do I have to go to use it? Right?

Brian Taylor: Right. They want to make it attractive and easy for them to do that. I get it. Makes sense. Okay. That's good to know. We're both audiologists, we're both clinicians, at least at one point in our career we're clinicians. So we kind of understand from the clinician's perspective some of the challenges associated with these kinds of programs. Let's look at Medicare Advantage programs and third party companies from their perspective. Why would I, as a hearing care professional, want to participate in them?

Patty Greene: That is a very good topic, a very hot topic to discuss. We know that can create a lot of emotion in the industry. I've spent a lot of time talking to providers and I totally understand it's an emotional discussion, but I think if we switch gears and take off our, just our clinician hat and we start looking at our business hat and get as much information. I always tell this to providers, gather as much information as you can about these programs and about third parties specifically in your area, and then make the decision for yourself. So why would they want to participate? Well, first and foremost, it's an area that's undergoing tremendous growth and that's going to continue to impact the clinicians directly because

clinicians are targeting primarily those 65+, right? Because that's who's going to primarily need the hearing aids.

And I'm not dissing anybody who works with children, I totally understand that. But for today's topic, we're talking primarily those aged 65+.

Brian Taylor: [crosstalk 00:32:46].

Patty Greene: And so as more and more of those enroll in a Medicare Advantage plan with a hearing aid benefit, and that plan offers a benefit because they partner with a third party company and they wouldn't have been able to do that without a company handling all those administrative tasks that we talked about earlier, this behooves clinicians to take a hard look at this. So the other thing is, and we'll get to the benefits. I know I'm giving you a long winded discussion of this.

Brian Taylor: No. It's all good. I think our listeners really want to hear this, so please go ahead.

Patty Greene: I kind of got to lead up to this, right? Give a little background first. So gather as much information so you can make an informed decision and understand that not all the programs or third party companies operate in the same way. So they really need to evaluate each company individually. But to go back to your question, why would a clinician want to participate? There are some inherent benefits of participating in the program. Number one is referrals. We know that 73% of adults in the US with hearing loss go untreated. So there's a lot of referrals out there or potential referrals out there. Many of those that enroll in a Medicare Advantage plan that partners with a third company look to their insurance to use that. And that insurance may require the plan to be seen by an in network provider.

So if you want those referrals, being in-network is going to help you get those referrals. So that's a value. For some plans, a clinician may not even be contracted with a health plan to begin with either by choice or because it's not an open network that they can join and contract with. So by partnering with a third party, it could open up access to referrals they may not have had access to before. Another, if we've talked dollars and cents here, in terms of financial benefit of joining a third party, there's no customer acquisition costs. So they're not paying a referral fee. They're not paying a marketing fee. They're saving money on customer

acquisition. And again, think of these consumers as we talked about before, they view hearing care a healthcare issue, and those with benefits are what, 20 to 50% more likely to purchase hearing aids, according to Market Track Nine.

And so the first thing they do is I have a hearing loss, that's a medical health issue. I have insurance. Let me call my insurance to see if I can get a referral someplace. And so people calling TruHearing for example, are further down that sales funnel and ready to purchase without the provider having to do any marketing to acquire those. And in talking about referrals again, because it is all about referrals as part of the benefit or the value to a clinician is looking at more first time users. We all want to bring in those first time users, right? They have a high value to that clinic. And I'll say that, I'll share a number with you in terms of TruHearing at least, I don't know the other companies that are similar to TruHearing, but two thirds of our referrals nationwide are first time users.

Brian Taylor: Yeah. That's a big number.

Patty Greene: Two thirds. So we are reaching those first time users. And again, when we're looking at that market share of 73% going untreated, we're dipping into that. So they're coming through TruHearing where they may not have done so before. They also, as I mentioned, dance around the purchase rate. They have a higher purchase rate, lower return rate because they're lower in that sales funnel. They're calling specifically to inquire about hearing aids. And if they have a benefit, they're going to be 20 to 80% more likely to treat their hearing loss. Now, also, when you have those patients come in from a third party referral, if they have good service from the third party company, they're happy with their insurance, they're happy with the provider, those satisfied patients, what do they do? They talk about it and they refer other patients who may be private pay.

And I regularly talk to providers who say that, say, "I get a lot of referrals from my TruHearing referrals who aren't even part of your program." So that's great. So there's another value. But of course, as the industry changes, another significant part of the value to clinicians in joining is that they keep part of the hearing care process. And this is something we educate plans about all the time. Because health plans will say, "Why don't we just go direct to the patient?" Because that's been done before. And so we educate the health plans about the value of the provider in the hearing care process. And so it's keeping them in their hearing

care process, which is not the case with some other purchases like direct to consumer and the pending OTC.

So those are some of the values of joining third parties. But before, I keep saying, providers need to get as much information. So before they make a decision, some other things that they really need to consider is how prevalent are those third party referrals and those health plan contracts in your area? If they are significant in your area and more and more people aged 65+ are joining Medicare Advantage plans offering a health plan, you really do need to consider if you're going to join them for that reason alone. And then what about your clinic hours? I hear providers all the time and I completely understand providers are very busy. I know things have changed with COVID, but they'll get back to being super busy as well. But my question is, are your clinic hours filled with revenue generating appointments?

All those appointments you see every day, are they generating revenue? Because if they are, then maybe third party is not a fit for you.

Brian Taylor: Right. You're already busy.

Patty Greene: Right. But if they're not, then maybe it is a good fit for you. But also when you're deciding which third party to partner with in addition to how prevalent are they in your area, is how do they work with operationally? What's the impact on your time and your staff's time and resources? So are they timely with provider payments? What's the appointment scheduling process? How prepared are those patients prior to the appointment? What's the ordering process? Are you having to fax to get pre-authorizations or not? How easy is it and how quick and easy are the billing and claims process and insurance verification? Because all of those play a role in a provider's decision on joining or not joining a third party. So ultimately, I'd say for the value of the provider or the clinician, they really need to do their due diligence so they can make an informed decision and not miss out on an opportunity.

Brian Taylor: Right. And you weren't kidding when you said, "I'm going to take off my clinical hat and put on my business hat."

Patty Greene: Yeah.

Brian Taylor: There are a lot of business terms there.

Patty Greene: And that's hard. And it's hard to do.

Brian Taylor: Yeah. It's hard.

Patty Greene: I was not trained in any kind of business aspect when I went to school. Of course, that was in the dark ages, but I was trained diagnostically.

Brian Taylor: Yeah. Same here. We learn on the fly so to speak.

Patty Greene: Yeah. Yeah. Exactly.

Brian Taylor: But what you're pointing out, I think when you put your business cap on and for some of us, definitely getting outside of our comfort zone, it's that you really are shining the light on how providers have to change or streamline their standard, not only business practices, but also their clinical practices in order to maintain profitability. So I guess what I'd like to ask you next, Patty, is can you talk about some of the things that they need to do differently when they get involved with third party contract business?

Patty Greene: Yeah, absolutely. Because it is a big shift and I empathize with providers. They have a lot on their plate. They're not only business owners, many providers, but they're also seeing patients. And so they have to juggle all those-

Brian Taylor: It's really hard.

Patty Greene: ... those two hats, so to speak. So I think three of the things I'd like to talk about really in terms of streamlining standard business practices to maintain profitability are really operational processes, staffing responsibilities, and compensation, and patient communication. Because really, things have changed so much that clinicians can't continue to do business as usual. So it's not to say they need to abandon the current business model altogether, but there are business practices that need to be examined to see if they still meet the needs of the changing business model with respect to mixed, private pay, and third party pay or if changes are needed.

Brian Taylor: Right. Okay. So let's look at each one of those three components that you just mentioned in more detail. I think the first thing you mentioned was operational processes, how do they differ in a traditional private pay market for if you're in a managed care market, how do you measure them, for example?

Patty Greene: As much as I'd like to give everybody a simple one size fits all answer, because I like that myself, it's not an easy question because each clinic operates differently. I'd certainly give things to think about, but each clinic really needs to look at their individual operational processes. Are they a small mommy pop kind of clinic or do they work in a large ENT or a hospital, or do they have 10 offices? The answers to this operationally are going to be different for each. But there's definitely some operational questions that they can ask. So I'll go over some of those questions that they can ask themselves.

Brian Taylor: Yeah. Sounds good.

Patty Greene: Yeah. One thing is, how do you decide which third party company to partner with as a clinician? Is it based on the prevalence of that third party in your area, the number of health plan contracts they have and how many referrals are going through third party? Is it based on their reimbursement amount or timeliness, your payment timeliness? Is it the operational ease of working with them? And then every third party company operates differently. So how do you keep current operationally on those requirements for each of those third party referral sources? Do you keep a printed copy of their provider manual for each company in a binder, or do you just go online and access that information? But who handles it? Operationally, you need to think of, do I assign somebody on staff to handle that and keep up to date on the requirements?

How do you monitor patient flow to ensure an acceptable mix of third party and private pay? Do you just schedule them in any available appointments lot or do you dedicate certain times and days for private versus third party? And then how much time on average is needed for a private pay patient versus a third party or different third party patients? Because some may come more prepared than others. And then certainly, since we're talking about operations, what role does your office management system play in helping you manage the operational aspects? So do you use your office management system to track the number of appointments by referral source? Because maybe you can decide, well, this one, I'm getting a lot of referrals. I'm going to work with them. This one I'm not. It doesn't warrant the time and resources to keep up to date. And how are you using it to track appointment type, private versus third party?

And certainly, I can say with respect to TruHearing and I'm sure a number of other third parties is how do you track the number of

visits so you know when to begin charging the patient? So often I go into a practice and they say, "Well, I don't charge patients." I'm like, "Why not?" And it really comes down to, I don't know how to track if it's their third visit, their fourth visit. And I've even said, "Put it on a sticky note in their folder if you have paper folder still." But there is a way in every office management system to do that. And then lastly, operationally, I'll just mention, monitoring revenue. How do you attract the exam fees and visit fees, and fitting fees because there's no customer acquisition cost and there's no, cost of goods is really what I meant to say. There's no cost of goods.

Brian Taylor: Right. And so what I hear you saying, Patty, is that when you are getting involved any of these kinds of programs, third party referral programs, that you need to be really strategic in how you handle the business, how you measure it, how you manage it in your practice.

Patty Greene: Yes.

Brian Taylor: That's good to know. I really appreciate your insights there with those questions, because I know that it's not a one size fits all approach. I'm guessing you're probably going to say the same thing about staffing and compensation. What do you need to do differently as far as staffing and compensation is concerned with respect to third party contracts?

Patty Greene: You're exactly right. So much depends on who is on staff and how large that staff is. And so I can just give you some examples of how I've seen this handled across the country as I visit providers in their clinics, because you're right, there is no one size fits all, but everybody should look at this and say, "How are we going to make this work in our clinic?" I've seen clinics where the clinician on staff or every clinician on staff, if there's multiple, works with every third party they're contracted with. So everybody does everything. Others I've seen where they dedicate one clinician to be like the third party expert. And if they contract with three or four third parties, that one clinician always handles all those referrals. So they become the expert.

Or if you have a large enough staff, maybe multiple offices, large enough staff, maybe you dedicate one clinician per third party referral company. So they're the expert on that company, so they can know how to handle the exams and the hearing aids, and what's offered, and how to process orders and get payment. Maybe it's everybody does one company. And I've also seen how

clinics utilize their front office staff and other axillary staff. Maybe they're the ones that submit handling the hearing aid orders, or they help handle the patient financing and collecting payments from the patient. I've seen others where the clinician does everything. So it really depends on the clinic. And then of course, as we're starting to see more audiology assistants join practices, what responsibilities can be delegated to them?

So there's different ways to handle logistics and operations depending on your staff. Now regarding compensation, because not all clinics pay their staff commission, but I've seen those that do handle it in several different ways. Some clinics don't vary the amount of commission for private sales versus third party because they feel third party reimbursement may be lower, but there's no acquisition cost and those referrals are more prepared to buy because they're coming in specifically for hearing aids. They're not coming in off mailing or a radio or TV ad. So they feel that there's less time spent on that, say, quote unquote, I know this is a dirty word in our business, but we'll say it, 'selling process'. So it kind of evens things out.

Other clinics veer their commission based on the amount of the provider fees they're paid. Again, no one size fits all, but certainly something to think about.

Brian Taylor: Well, and I'm guessing for the third factor, you mentioned patient communication. Could you speak to that and how that's managed with third party contracts?

Patty Greene: Yeah. It's really about the provider-patient communication when I talk about that. One example is that providers need to consider how and when they'll communicate charges for visits and other services. And also, how are they going to talk to patients who previously paid out of pocket? How are providers going to explain the cost difference? Because all patients want to feel good about their decision to buy hearing aids. And providers maximize their revenue potential with third parties by fitting hearing aids. If you have a positive conversation, you make the patient feel really good about buying the hearing aids, the patient will benefit and get what they really came in for, but the provider will as well.

So that positive conversation with the third party referral about their health plan's role, the cost savings and value helps the patients gain a clear understanding of the value of the program. But it also helps them feel positively about their decision to

purchase aids. So it's a win-win for both the provider and the patient.

Brian Taylor: I see. I see. Well, I guess maybe this is a little bit of the elephant in the room now, but I wanted to get at-

Patty Greene: I know what it is. I can guess it.

Brian Taylor: Well, and I'll just speak from my own experience. A lot of providers are [inaudible 00:49:29]. They feel like they're not making as much money or whatever term you want to use. Gross margins, it's lower with managed care business than it is with out of pocket private pay business. So I guess my nice way of asking a question around this is, what's the economic value of these third party contracts and how do you calculate it?

Patty Greene: That is the elephant in the room. And I get that question a lot, and I'm glad to have that question because I think, well, first off, I'll just say right out the gate, you're not going to make more money on a third party fitting fee, professional fee than you will private pay. You're not going to. Okay. So there's that answer. But it's also, it comes down to being able to calculate that profit correctly. You can't take your retail price for private pay, subtract your cost of goods and say, "I've just made X thousand dollars on that." That's not even accurate. So what it really comes down to is providers being able to calculate profit accurately by calculating the profit per patient per hour.

Now, historically, providers have been able to measure ASP or total number of hearing aids sold annually to determine the financial health of the retail clinic. However, because as we know, competitive market pressures have reduced margins on hearing aid sales, as you just mentioned, and because not all hearing aid sales are 100% out of pocket, profitability has to be measured differently. And I do want to say, because there's confusion here is that it's important to note that your profit per patient per hour, which I'm talking about, and I'll talk a little bit more about is different, a different value and a different calculation than how much revenue needs to be generated to keep the doors open. Because in that calculation, you're going to take into account overhead, such as salaries, taxes, insurance, et cetera.

And those expenses are present regardless of whether you accept third party referrals. So what providers really need to understand how to do is if they want to know what the economic value of a

third party referral is, is to be able to measure that profit per patient per hour for a private pay patient and a third party patient individually.

Brian Taylor: Okay. Understood. And so I know that no size fits all. There's no such thing as average. I think we've already covered that, but could you share with our listeners a good range for the typical audiology practice with respect to this variable profit per patient per hours?

Patty Greene: Okay. Here we go with averages again, Brian.

Brian Taylor: Well, you got to start somewhere. Right?

Patty Greene: I know. It's all good. And I will get to that. But before I answer I'll just say, providers shouldn't rely on averages to make decisions for their own practice. So first and foremost, I'd recommend each clinic consult their own business financial advisor to help them determine their profit per patient per hour. It's not a pitch, but alternatively, TruHearing's created an easy tool that providers can use to quickly calculate their profit per patient per hour independently for their private pay patients and TruHearing referrals. It takes into account all the metrics needed to accurately perform this calculation because you can't, again, you can't go buy, here's my retail price, subtract out my cost of goods. This is what I made on the private sale. TruHearing's paying me a fitting fee of this.

That's apples to oranges. If you use the profit per patient per hour, you're going to take into account more metrics. And so I'll give you a little bit of an average here because you asked me. When we've used this tool with TruHearing providers in the past using their own clinic data, that range has been between 260 to $400, again, profit per patient per hour.

Brian Taylor: Wow.

Patty Greene: And so if not overall profit, that's what they make per hour.

Brian Taylor: And that number, 260 to $400 profit per patient per hour is the range, right?

Patty Greene: Yeah.

Brian Taylor: So I know I'm good with ranges. I completely understand why a range would be very useful and you can't really go beyond that unless you're... and I've been to that, I've used that calculator you mentioned, it's really a terrific tool. So I hope people check that out on your website.

Patty Greene: Yeah. They can just a little, because I do want to help providers understand this because this is the big elephant when it comes to third party is reimbursement. And so there's a YouTube video that gives you a high level overview of it. And this isn't, we'll send this out to any hearing aid manufacturer to share as well because we really want providers to understand this, and they can also call us and we'll send it to them as well.

Brian Taylor: Right. I think the other thing I wanted to mention here is, other healthcare providers outside of audiology, just about any, physicians, you name other non-MD healthcare providers. I think they've been dealing with these issues for probably longer than audiologists. We're no longer immune to the forces of managed care and being more efficient and juggling these things.

Patty Greene: Exactly.

Brian Taylor: Right. I know we're probably going to go a little over on our time and that's fine because I think we're really discussing some valuable things that providers want to know more about. But based on our conversation so far, Patty, it sounds like practices really need to manage their business from third party contract separately from their private pay business. I'm assuming that you agree with that. It's like two separate businesses in a sense. And what are some of the key performance indicators that are different in third party business compared to private pay?

Patty Greene: I do see them as kind of operation or... business wise, they need to think of them differently because they really need to understand, especially when you have your business hat on and you're saying, "What am I making on those third party contracts versus what am I making on private pay?" And a continual evaluation, not just a year end evaluation of the financial health of the clinic is important. This is something of course, understandably so that providers are most concerned about is how much profit are they making from third party versus private pay. Again, I mentioned earlier, they're not going to make more money on third party, that particular patient, but it does, the business equation is shifting from low volume, high

margins private pay to high volume, low margins managed care, as you mentioned in all other healthcare disciplines.

Again, it really, for this particular case, it boils down to being able to measure, and this is a mouthful, that profit per patient per hour for each patient type, private and third party. Because when you're looking at that, some of those metrics that you need to measure that apply to both a private pay patient and a third party and some that only apply to one. For example, cost of goods and customer acquisition cost. You have those involved, those are two of the metrics that they should be aware of and measure for private pay, but you don't have cost of goods or customer acquisition cost for third party. So you need to measure that separately. They also need to measure for the average number of visits per patient in the first year post fitting. Average number of minutes spent on a hearing exam.

Time is money. How much time you're spending on your fitting visits and your followup visits. All of those metrics impact profitability. Looking at closure and return rate, closure rate and return rate, or purchase rate and return rate are some of the other metrics that need to be tracked independently. So only when all of those metrics which influence profitability are tracked can one accurately calculate the profit per patient per hour and compare the profit for a third party referral to that of a private pay. So it's much more involved than just cost of goods, fitting fee and retail prices.

Brian Taylor: Right. It forces a clinician to master some new terminology, I guess.

Patty Greene: Yeah.

Brian Taylor: All right. Well, I wanted to maybe turn our attention now to TruHearing programs. One thing that I wonder about is, does TruHearing pay for hearing tests?

Patty Greene: Ah. The simple answer, and I got this a lot when I first started with TruHearing is it depends. And I would say, well, how am I supposed to remember this if everything is, it depends. So it does, it depends on the health plan and that's because the health plan decides what benefits to offer its members. So for some of our health plan partners, for the exam, the patient or the health plan member pays a copay for that exam just like you or I might pay for a copay to visit a doctor's office. And that's the agreement with the

health plan. That's what the health plan wants to offer. TruHearing then submits the claim to the plan on behalf of the provider. So the provider doesn't have to do the administrative work and then remits the full allowable amount for that exam back to the provider.

And TruHearing doesn't retain any monies for hearing tests. So whatever the health plan pays, TruHearing pays back to the provider. We just process that claim for them. So that's a value to the provider. For other plans that we partner with, it depends on the provider's contract with the plan. So if they're in network with that plan, they simply abide by that contract that they already have with the plan and bill accordingly for the exam. If they're not in network, they can charge the patient $75 directly.

Brian Taylor: All right, Patty, it sounds pretty complex.

Patty Greene: It is. The insurance world, as we all know, and anyone who works with insurance knows it is very complex. However, TruHearing understands that and we make it easy for providers because we have what we call a patient overview sheet available in each patient's record and echo our provider portal. And that outlines to the provider for every single patient how do they handle the exams and the hearing aids, and billing, and collecting payments, et cetera, and what the benefits are offered to each patient so that the provider doesn't have to memorize the details for every insurance plan.

Brian Taylor: Right. It also reminds me that it's really important to have an extremely detail-oriented office manager that can [crosstalk 00:59:49]-

Patty Greene: Okay. So in your office, you're going to delegate. That's good.

Brian Taylor: Well, yeah, I'm about delegating this because this is something that, there's other people out there that are much better than I am at doing stuff like that.

Patty Greene: Yeah. I hear you.

Brian Taylor: But it's good to be... You've definitely reminded me about how complex that can be to remember, but I guess the next question I have about TruHearing benefits are, just tell us about a first time hearing aid buyer that might have TruHearing, how many office visits over the course of the first year? This is a question that I hear an awful lot in the field.

Patty Greene: And this is a source of confusion. I'm glad you're asking that. Overall, any person who purchases hearing aids through TruHearing, in addition to the significant out of pocket savings they receive on their hearing aids, everyone receives the same offerings, which are 48 batteries per aid for the non-rechargeable, of course, for every aid purchase, a 45 day risk trial. And this is what I really want to clarify, the provider visits, they get three provider visits and that's the fitting visit and two followup visits that have to be used in the first 12 months after purchase. After that, the provider collects $65 per visit from the patient. And that includes a telecare visit. That's considered a visit.

The only exception to this, and this is for all TruHearing referrals. The only exception is for members of the UAW Trust. The UAW Trust requires that their members receive six months of included visits. And then the member pays a $20 copay per visit after that. But TruHearing will remit $45 back to the provider. So the patient pays 20, TruHearing gives the provider 45.

Brian Taylor: Got it. I'm glad you clarified, three provider visits, one visit is the fitting, two follow up visits used over the first one year, correct?

Patty Greene: Yes.

Brian Taylor: And then after that, the provider can collect $65 per visit.

Patty Greene: Yes, exactly.

Brian Taylor: Okay. I just want to make sure I was clear on that. It also reminds me that it's really important for clinicians to be as efficient as possible to make sure that patient is receiving optimal benefit, is highly satisfied with three visits essentially whenever possible. So what advice or maybe some best practices you've heard or seen could you share with our listeners to be more efficient in this regard?

Patty Greene: Based on everything that we've discussed today, it's evident that, I know this is kind of hurtful for providers to hear because we want everything to be the same, but really clinicians can't continue with business as usual. Everything is changing, and I think that providers should carefully consider how the market is changing, the shift in Medicare Advantage, growth and enrollment, and hearing aid benefits especially if they look at what's happening in their particular region and for those who are able to streamline their business practices, like some of those items that we talked

about before with operations, staffing, and patient communication, those providers will continue to thrive. It's going to be different, but you can certainly continue to thrive.

So each practice needs to take a close look at their own operations to look for ways to manage time and staffing more efficiently. And they need to look at, again, as I mentioned, the influence of managed care in their particular region so they can make informed decisions for their practice, not what maybe their colleague is doing or their friend in another state, but what's going to make most sense for their particular practice.

Brian Taylor: Right. No, that makes sense. My two cents worth on this is it's really important from an efficiency standpoint to follow established clinical best practices. What AAA guidelines might say, stick to the science of what works because in a managed care arrangement, you really have to do more with less. Anyway, I know we're a little bit-

Patty Greene: I think that's-

Brian Taylor: Go ahead.

Patty Greene: Just real quick though, but I think that's where it comes down to is how are you managing staff, time, and resources? Are there other items that can be delegated to front office, an audiology assistant, maybe someone, if you're the business owner, someone that's not the high cost part of the business that you can delegate some other tasks to to be more efficient.

Brian Taylor: Right. No, that's a great point. Now I know we're over time and I want to go off script a little bit, so to speak. I've actually two follow up questions, Patty, that I want your insights on if you don't mind.

Patty Greene: Sure.

Brian Taylor: Okay. First one, you mentioned in a true hearing or any sort of a managed care arrangement that there are no customer acquisition costs. Can you talk about how that, in the private pay market, what do you find to be the, and there's this word again, average acquisition cost? What are the range of.... I know that we're getting in marketing, but how much does it usually cost a practice-

Patty Greene: No. That's okay.

Brian Taylor: How much does it cost a practice to acquire a patient in the private market?

Patty Greene: This is something I have a lot of experience in from my previous position with another hearing aid company is in marketing and helping providers acquire customers. And it's varied significantly. At some of the recent industry association meetings or conferences that I've attended, I've seen as low as $800 per patient to over $1,000 per patient. When I talk about the average revenue that you're making from like a TruHearing referral and using our tool, we're only putting in $500 customer acquisition cost. Because we're considering a lot of providers will also do database mailings, right? And reach out to their current database. So it's going to cost less to bring that patient in, but I've seen anywhere from 800 to $1,000 per patient, just to bring them in the door, unless they're a repeat patient.

Brian Taylor: No, I think that's a solid number. I think sometimes providers forget, like managing your website, social media, there's a lot of components that add to the cost of acquisition and marketing.

Patty Greene: Right. And the other thing I'll add is that when you look at what is your customer acquisition cost, you have to look at every patient that comes into your practice. If you look at your, really the definition is the annual marketing spend divided by the total number of sales opportunities. So it includes all patients who you saw and tested, screened, demoed, and trialed or recommended hearing aids even if they didn't purchase. So when you start looking at all of those sales opportunities and add them into that marketing equation, that's where the cost goes up. Just because you didn't sell them doesn't mean there wasn't an acquisition cost to get them in the door.

Brian Taylor: Right. No, that's good to know because I know there's a lot of questions about that number and where it comes from and why it's important to calculate. The second thing I wanted to ask or that maybe is the final question is, and you mentioned it at least twice early on in our conversation and that is, attracting members into a third party program, three kind of carrots, I guess, controlling costs, utilization, and quality. Could you speak to those three things, how they fit together and how that's changing the landscape?

Patty Greene: Sure. Yeah. So of course, that's the definition of managed care is to control costs, utilization, and quality. And so in a health

insurance setting, that's what they're looking at. So one of the ways that a health insurance plan controls costs is, in our topic today is to partner with a third party because rather than the health plan absorb the cost to hire people, to have the knowledge and resource for such a small healthcare discipline in their world, it's big in our world, small in a health plan's world, they manage the cost of that by hiring a third party to handle all the outsourcing of the network, like I said, and education to their membership. They handle processing claims, credentialing, contracting, all of that work the health plan doesn't have to do.

So they say, "Hey, if we can have TruHearing do this, it's going to cost us less money by doing that. So it'll also help us be competitive by being able to offer a hearing aid benefit. So yeah, we'll do that because it saves us money." And sometimes it's millions and millions of dollars. Utilization, there you go. That if you don't want health plans, don't want every single member to purchase hearing aids, that's high utilization. So that could cost them a lot. So there are some health plans that contract and they pay a flat fee to their third party. They're paying per member per month. Maybe it's two cents a member per month. So that's, they already know what their cost is going to be regardless of how many members take advantage of that. So in that case, utilization risk is on the third party because if they have a lot of members who use it, then they're only making that two cents per member, there's going to be a high cost factor there.

And then the last, quality. When they partner with a third party, I'll give an example of TruHearing just because I know TruHearing very well, but it's the case with the other third parties too. They can still offer high quality products and high quality care. We're very proud of the providers in our network. They're excellent providers, so they are providing high quality care. And we are proud of the hearing aid manufacturers that we partner with as well because we have top hearing aids, top quality hearing aids to offer. So it's managing the cost and quality for the member as well, but also utilization for the plan. Does that answer your question?

Brian Taylor: Yeah. It does. Because I think the future when I look at it, as more and more managed care business, those things fit together and it's really important for a clinician to have a plan in their practice around how they contribute to this, the three things, controlling costs, utilization, and quality, how they fit into the bigger picture. No, that's really helpful. Anyway, Patty, we really appreciate your

expertise and your insights. If people want more information from you, is there a way that they can contact you?

Patty Greene: Sure. If you have any questions, you want more information, you want to contact me directly, my email is Patty, P-A-T-T-Y.g, as in Green, @truhearing.com. So patty.g@truhearing.com.

Brian Taylor: Well, Patty, thank you very much for your time. This has been, I think it was a very informative session.

Patty Greene: Thank you, Brian. I really appreciate this time today and I really hope that we've given some additional insight, knowledge, and information is really what we hope to disseminate to providers' unanswered questions.

Brian Taylor: I think our listeners thank you as well.

Patty Greene: All right. Thank you so much.

Brian Taylor: Okay. Thanks.

Patty Greene: Bye-bye.

Brian Taylor: Bye Patty.

Patty Greene: Bye-bye.

Brian Taylor: Bye. Thank you.