HCAA Insights: TPAs Have the Power to Positively Impact Members and Their Health

In this edition of HCAA Insights, we'll examine how TPAs can improve healthcare for all through an empathic care navigation model that treats the "human side of healthcare" while having the cost savings follow suit.

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3 Healthy Work Habits for Today's Uncertain Times

At JP Farley, we feel an obligation to do the best for our employers and their members. If we do the right thing, we're going to keep a client for a long time and the investment is well worth it. TPAs who truly want to save their employers money while raising care quality for their members should be doing this already. And if you're not, the time to start is now.

— Michelle Bounce, Chief Operating Officer, JP Farley

I came to the TPA industry about a year after a life-changing medical ordeal that deflated my opinion of healthcare and how providers and insurance companies treat patients. I'll tell you that story in a moment.

But I learned from that experience the importance of empathy, and now as a TPA I know the vital role that TPAs can play in the lives of the members they serve, primarily to point members to cost-effective and quality care. The benefits extend to the employer groups we work with so they can continue to offer healthcare to their employees. We can share in those savings and increase loyalty among our clients. But most of all, we can improve the lives of our fellow humans, helping them manage chronic conditions and receive the best of care — all by using the claims data we already have and taking a more proactive approach to truly serving our members.

A Life-Changing Personal Experience

Many of you have experienced the first fetal ultrasound, when you and your spouse glimpse arms and toes and learn — if you want — the sex of your unborn child. That was me and my husband 17 years ago. I was in my 20s and had been trying to get pregnant for a while.

We went through the journey very excited when it finally happened, and I got to five months and we went for our ultrasound to find out the sex of the baby. The technician's doing the procedure, and she tells us we are having a boy. We start celebrating, when the technician all of a sudden says, "I'm going to leave the room and get the doctor."

The doctor returns immediately and takes us to what I now call the padded room, basically a room with couches and flowers, and explained to me that my baby had anencephaly and would not survive, and that the best thing for my body would be to eliminate the pregnancy now. I'm crying, and the doctor looks at me and says, "You're young, so you can get pregnant again." He didn't understand why I was so impacted by this.

I come back to the clinic a couple days later for the first part of the termination. A doctor I've never seen does a 15-minute procedure where your cervix is filled with a seaweed-like mixture that absorbs the cervical fluid and starts to abort the pregnancy. I remember so clearly being home that evening, curled up in a ball on the couch and screaming at the top of my lungs at the thought of losing the child that I wanted so badly.

No nurse called. No doctor called. No therapist called. I was alone on an island.

The next morning I go into the hospital for a D&C, which takes place in the maternity ward, of all places. I remember being in shock, because there's a very pregnant woman in labor walking the halls with her husband, and I am walking in to lose my child. It felt so impersonal and traumatic to hear a lullaby playing and feel so much excitement and happiness going on around you.

A few days after the procedure, a care manager from the insurance company called and said, "How's it going? Are you bleeding? Is anything going on?" Very clinical. I'm trying to explain that, physically, I guess I'm fine, but mentally, maybe not so OK. And they're not equipped to deal with that. I explained that it was really hard to go to the maternity ward and the response was, "Well, that's where they had the equipment."

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From this experience, I decided never to have children, which cost me my marriage because my husband really wanted them. Everything works out for the reasons it's supposed to, but I walked away from this life-changing event realizing how impactful healthcare experiences can be for people when they're at their most vulnerable.

For me, it was the decision not to have children. For others it could be picking the wrong physician and losing their mobility because of a bad outcome. Or it could be something less catastrophic like receiving a balance on a medical bill. As TPAs, we may treat medical issues in a very factual manner, but how we treat these issues could cause financial ruin for somebody. It could impact their ability to buy a house, put them in debt or create enough stress that bad things happen in their lives.

I found it very upsetting, very depressing that in our industry and in the greater healthcare industry it has become a large business and is not about the human being in the center of the interaction anymore. We have completely forgotten the human being, and we must do better.

Keep Members' Best Interests at Heart

Change starts at the TPA level. At JP Farley, we hire people for empathy. We seek people who really want to connect, which is hard over the phone. But this is a time when people are at their most vulnerable, and that connection is so vital for what members are going through.

How are you picking up the phone? We don't have a phone tree and make people wait 15-20 minutes to talk to someone. We make sure the person who answers the phone is not transferring members or pushing them around. We have advocates, not customer service representatives.

Thirty percent of our phone calls now are outbound calls, and that has made a huge difference for our members and their perception of us. For example, something as simple as a colonoscopy that gets processed toward a member's deductible because of a polyp can generate a phone call. Our members don't understand how to remedy a claim they might think was processed wrong. They don't know who to call or what to do. My neighbor went through that on his own, and even with my help, he's still dealing with it a year later. Our Staff saying something as simple as "Let me make that phone call for you" is a huge step forward for the member on the phone.

We have care managers, we have the data, and there are so many places where we can connect. We're not clinicians, but we as an industry are at a place where we're hoarding data, instead of figuring out where can it be shared and how can it be shared and when should it be shared.

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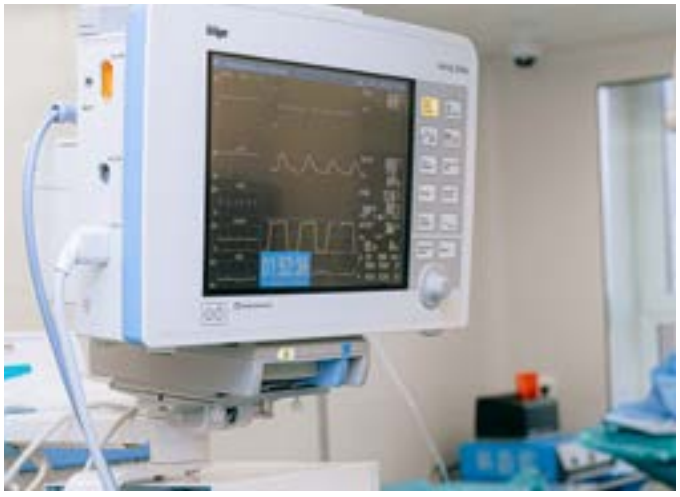
We have care managers, we have the data, and there are so many places where we can connect. We're not clinicians, but we as an industry are at a place where we're hoarding data, instead of figuring out where can it be shared and how can it be shared and when should it be shared. We can share when we're partnering with physicians or clinicians and nurses and direct primary care clinicians (DPCs). We need to find those partnerships and those places where we can connect the dots with data and help clinicians make purposeful, data-driven decisions that benefit our members.



One of those places is giving members an incentive to call us first when they are told they need surgery. We can connect them with a quality hospital and a quality surgeon for the type of surgery they need. And we can incentivize them by waiving the deductible and coinsurance to make sure they have a quality experience that will cost us — and them — less money.

Early Interaction Can Move the Needle on Quality, Cost

I'll admit it can be a hard sell to convince a member to let a TPA get involved in their care. One of the first things we do is provide education, but, obviously, that education is not focused on cost. People get very offended when you're talking about cost. You have to change the conversation to quality.

But our membership has access to Google, and the search engine is not telling them anything about the quality standards of a physician or hospital. It is really hard for members to determine how to find quality. We have access to this data.

We should use it both for the benefit of the employers we're serving and to help the humans we're serving. If a member has a better outcome, it costs the plan less money, but you have also impacted a life in a positive way. And all you have to do is look up a quality provider.

We recently did a case study that illustrates the point. Consider a cervical spinal fusion. Without guidance to a quality physician, a member had the procedure. We did pre-op and post-op for that member and did a cost analysis.

For the member who did not shop quality, the cost was $255,367. The cost for a member who called us beforehand and did shop quality was $132,935. But consider the quality standards for the spinal fusion, which tell an even more compelling story. Cervical spinal fusion is a big procedure, a life-changing event, and quality matters. The hospital quality for our cheaper procedure was in the 98th percentile, and the physician quality score was in the 90th percentile.

The hospital quality for the member who did not consult us beforehand was in the 64th percentile, and the physician the member chose was in the 24th percentile.

The spinal fusion for that member who didn't choose to use an advocate cost the plan twice as much and placed the member at incredible risk. And the member had no idea of the risk and would have had no way of finding this information.

We see the same results with knee replacement: $39,000 for a facility in the 99th percentile for quality versus $108,000 for a facility with a 16th percentile rating.

TPAs must engage the member through education and helping them understand the importance of quality.

Starting the Quality Conversation

Starting the conversation with members depends on how care management is set up. Most TPAs use a quality tool where members can compare multiple physicians and multiple hospitals on one page so they can see quality side by side. You can incent members by telling them if they choose the highest quality providers that you'll waive deductible and coinsurance.

What we found interesting is that our nurses and our physicians want to help our members. They want to make sure they're getting better care, but they don't have the data to do it. They don't have the information early enough.

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We have advocates, but there is a lack of trust because we're the "insurance company" in members' minds. It helps to get clinicians and nurses and care managers involved because members will trust them at a higher level than someone from the administrative office.

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Often, we don't know what's going on until the pre-certification for a hospital surgery happens. If somebody is scheduled for a knee replacement in 36 hours, I am not getting them to change hospitals and physicians — no matter what I say.

But there are so many things that we can do with the data we have. We can look for all patients who have had steroid injections or hyaluronic injections, and I can report these proactively to an orthopedic surgery center of high quality or to our nurses or to a DPC.

This allows us to get ahead of an actual major event and steer the person toward quality before they're facing a surgical procedure. In many instances, we can help members avoid a surgical procedure altogether.

We complain about how frequently people go to the ER, but what if we could engage members to reduce future visits? Patients are discharged with instructions that call for a follow-up visit with a physician. How many patients actually follow-up and how many return to the ER days or weeks later?

The hospital calls us about benefits and co-pays while the member is at the hospital. What if you created a trigger or a notification to the clinician, saying patient X presented at the ER and please reach out to that member?

Other low-hanging fruit where TPAs can get involved include people with multiple comorbidities and those with gastrointestinal issues such as IBS or IBD. These are big claims, chronic claims, and they happen in the ER and in-patient year after year.

Create an automatic trigger for one condition or two to start. Even a weekly or monthly report would be better than what you're probably doing now. The key is to start somewhere.

Partner with Physicians in Member Care

Being proactive applies to physicians and other clinicians, too, those who are receptive to the information. Providers want to do the right thing, but doctors see patient after patient and run from exam room to exam room.

To help physicians, we created what we call the "magic three-pager," a patient summary the provider can review right before seeing the member. And it's not a bunch of words — it's charts. While walking down the hall, the provider can at a glance understand the history, the medication and what's going on with that patient.

We've all been to the physician's office. You talk to the physician's assistant when you go in, and she asks you this group of questions. Your physician walks in 10 minutes later and asks you the same questions.

Anything we can do to cut through those questions and get to patient care quicker will help both the physician and the member. Orthopedists and specialty physicians love these alerts, but you can't send over raw data — you have to scrub it to make it meaningful, which isn't hard for TPAs to do.

Care for certain members just costs more. We need to identify those members where we can increase care quality, reduce costs and give physicians vital data they need. We also need to figure out how to perform outreach, whether via our advocates, our care managers or a web portal for scheduling.

TPAs Have the Power to Make a Difference

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We have a more comprehensive view than a physician or a hospital does in most cases. Providers use different EMR systems, and patients visit different doctors and/or hospitals on their healthcare journeys.

But TPAs have claims and procedures and prescriptions across the spectrum of care. We can piece this together quickly and get a much fuller picture of what's going on with the member. But we're not clinicians, so what's the value to us? The value is providing a comprehensive view of the patient to clinicians to better inform care for our members.

TPA care managers, in my opinion, have gotten lazy. We get involved at the pre-cert level and have turned it into a business of stop loss renewal.

We only care about what's going on when we're up for renewal, evaluating what's going on with our large claimants and not trying to impact them in a positive way. I'm evaluating them because I have got to negotiate my stop loss renewal. But we can reduce the costs associated with most large claimants while improving their lives. And that has value.

Let me share another example. There is a company that's been with us for about a decade, a great employer but one with only 47 covered lives.

The child of an employee has muscular dystrophy, and we knew a new drug was coming out, and we knew it was expensive, $1 million year after year. Let's be honest—if the small employer takes on an expense like that, there's no way that employer is getting fully insured or would be able to self-fund.

Using the data we had, we were able to understand the member's needs, understand the patient may or may not have been eligible for the medication and started communicating before any drug was prescribed.

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Our efforts kept that employer in business with a health plan. Not every data pass will produce $1 million in savings, but we have vital information at our fingertips that can help members and employers make better choices. And satisfied employers who are saving money will be more likely to renew with you, a classic win-win-win for TPAs, employers and members.

Taking it One Step at a Time

Changing the member mindset to call us first doesn't happen overnight. Front-end education with members and incentivizing them to contact us first is critical. You must recognize that getting good traction could take 18-24 months, so you need to be patient. You need a few good stories from members who share them with co-workers.

I remember an employer where we added Teladoc virtual care, and hardly anyone used it for the first year. Then one person called me about a positive experience: "They answer the phone in two minutes, and I talked to a doctor and he gave me an antibiotic. It was so cool." The next month, the Teladoc utilization went up 50% at that client.

Creating impacts like that makes me wake up feeling really good about what I do. If you say you're going to provide incentives, do it and do it in a timely manner because members will quickly get frustrated with the process. They are already going through a stressful event. We do not want to create more stress for them.

You can easily save 20%-30% for a particular employer over a few years through proactive care management, which will definitely help at renewal time.

We have the know-how and the tools to mine our claims data. We have the technology and the analytical tools, so it's amazing to me that more TPAs aren't doing this. Evaluate the claims data and determine where the low-hanging fruit is, places where you can impact costs and improve member lives. Is it orthopedics? Gastrointestinal disease? Chronic diseases?

Pick a focus, find the relevant elements in your data, extract them and pick an internal or external advocate, an empathetic person who's willing to invest the time to move the needle.

The best person for outreach is likely a nurse or clinician because they understand the medical side, the quality side and the need for empathy.

The focus becomes how to incentivize people to use the available benefit, and you must incentivize correctly the first time. I've seen cases where the incentive wasn't communicated correctly, and it takes a long time to happen or fails to happen. That's the quickest way to betray trust, and it's really hard to build that up again.

Getting Paid to Do the Right Thing

At JP Farley, we feel an obligation to do the best for our employers and their members. If we do the right thing, we're going to keep a client for a long time and the investment is well worth it. Many TPAs might have a difficult time justifying that initial investment. But you can either charge case management fees or take a percentage of the savings that you generate. Those arrangements are common and should be readily accepted by your clients.

A deliberate approach on one condition should show an outstanding ROI that will resonate with your employers. Not every ROI will be that million dollars we found for the muscular dystrophy case, but it doesn't take many $120,000 savings on a single spinal fusion surgery or $70,000 on a knee replacement to build a nice ROI.

TPAs who truly want to save their employers money while raising care quality for their members should be doing this already. And if you're not, the time to start is now.

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