Patient advocacy programs seen as engine that powers not only health engagement, but also reference-based pricing model

By Bruce Shutan

Patient advocacy programs have gradually emerged as a critical link between efforts to engage self-insured group health plan participants in better decision-making and growing use of reference-based pricing (RBP) methods to control soaring costs.

Without assistance from a patient advocate, who acts like a concierge of sorts, "employees are accessing a complex system with one hand tied behind their back," observes Chris Fey, CEO of Big Bang Health, a full-service health care startup that made advocacy the hub of its approach.

In fact, having access to this invaluable service could be a matter of life or death. "Unless you have a care advocate or complete trust in your physician's diagnosis, you're operating at a disadvantage," he cautions, citing a recent Mayo Clinic study suggesting that 20% of diagnoses by primary care physicians are actually incorrect. "As they go down that misdiagnosis trail, they're spending up their deductible, and then they're getting tested or are going to trigger the employer claims data. That's going to drive up their costs one way or the other."

Even among patients who are diagnosed correctly, Fey says the research suggests they have only about a 50/50 chance of receiving their recommended evidence-based cure guidelines.

"How do you tap into the CMS database on every known provider in the country and get the morbidity, mortality and readmission rates?"

he asks rhetorically.

"That's beyond the typical person, so I think it makes prudent sense for every single individual who is accessing the health care system to have a care advocate. It's a no-brainer."

The mission of a patient advocate is to send patients to the right provider who will not only accept negotiated prices, but also demonstrate quality in their practice or institution, says Tim Martin, EVP and general counsel for Payer Compass, LLC. The result will be "better clinical and financial outcomes on the back end," he adds.

One key to success is establishing a lasting relationship with medical facilities that allows health plan members unfettered access to the care they need. This collaborative approach also eliminates any worries they might have about incurring unaffordable out-of-pocket costs for critical services.

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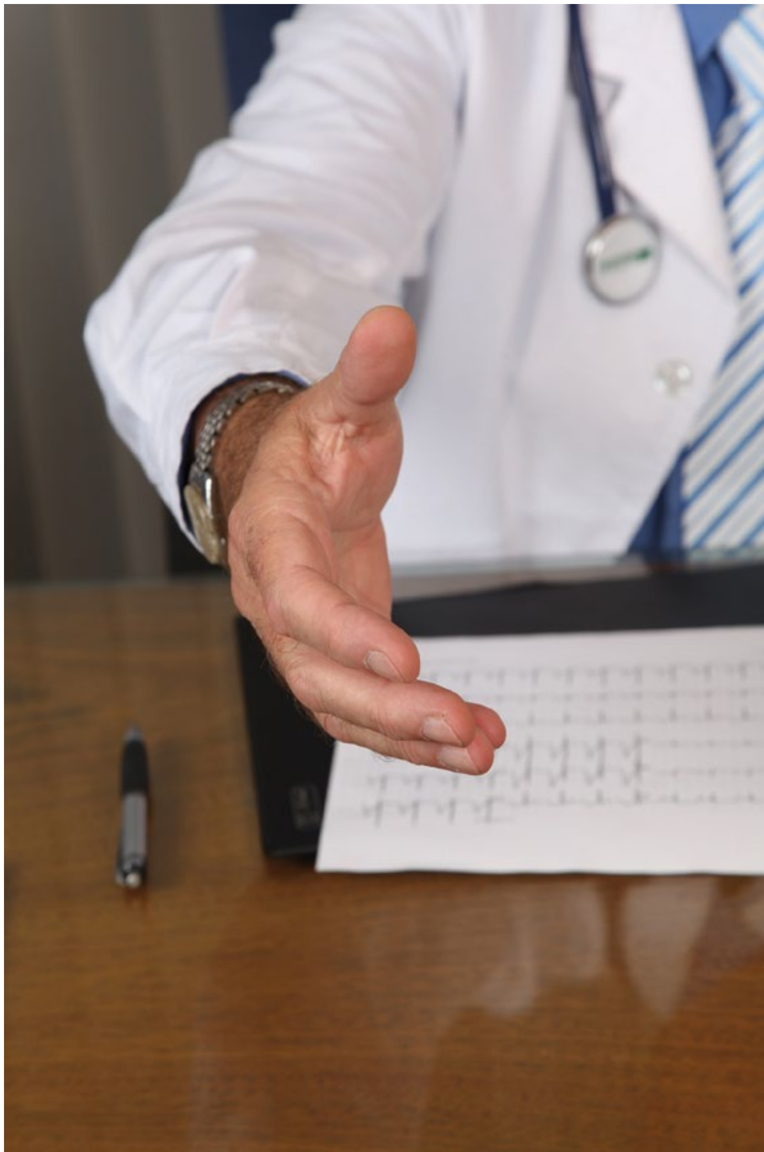
Martin, who sees see some plans with a zero deductible, cites an old adage: "It's easier to get forgiveness than it is permission, but we find in this business, it's generally better if you get permission than to seek forgiveness."

Patient advocacy proponents in the growing RBP space have been busy trying to build a better mousetrap for their self-insured clients. Noting that elective admissions account for more than 90% of admissions, one industry insider developed a pre-pricing technology tool that adds to the pre-authorization process. The result is less than 2% RBP pushback from providers compared to a 5% to 10% range across the industry.

"That's been dramatic in terms of telling them what they're going to get paid before services are rendered, and if they don't like the number, we can negotiate it up front and they can continue with the admission," explains the source, speaking on the condition of anonymity.



With more than 20 regionally focused databases to price all medical services nationally, his firm also negotiates safe harbor provider agreements with the hospitals to avoid balance billing.

Marketplace traction

Slightly more than half of 2,544 employers surveyed provide their employees with access to a health advocate for help finding the right medical provider, compare costs and resolve claim disputes, according to Mercer's latest National Survey of Employer-Sponsored Health Plans. The number is a bit higher in Aon Hewitt's 2017 Health Care Survey, which found that 59% of employers provide advocacy services and 29% may add them in the next three to five years.

With virtually all Fortune 1,000 companies self-funding their health benefits, anywhere from 50% to 75% of them offer some sort of internal or external patient advocacy, surmises Abbie Leibowitz, M.D., chief medical officer and president emeritus of Health Advocate Solutions, a subsidiary of West Corporation. He adds that "it is a broad definition of services that doesn't truly lend itself to standardization around any industry model."

The pain points, of course, are particularly raw for self-insured employers that take on the full risk of all medical costs, according to Fey, who also notes the possibility of an impact on reinsurance costs. But he says advocates can help steer patients to a proper second opinion and meaningful quality comparisons. They also can offer "the correct set of directions to navigate the system" en route to a better clinical outcome and improved savings, he adds.

When industry pioneer Health Advocate Solutions began 17 years ago, its biggest challenge was explaining why the service was needed. But nowadays, Leibowitz says "everyone wants to be your health advocate."

Several factors have driven the company's growth in the self-insured marketplace. They include the popularity of consumer-driven health plans (CDHPs), changes in benefit structures, narrow networks and a reluctance to hire more HR staffers to help employees navigate their way through an often confusing system.

Steve Kelly, president and CEO of ELAP Services, has seen scores of players unfurl shingles as patient advocates. However, there must be baseline measures for which these new ventures pass muster. "Our conviction is that it really has to be durable and follow the patient for an extended period of time," he says.

That means a willingness to stand in patients' shoes with a specific objective in mind that transcends providing general information over a toll-free hotline. It includes an awareness of how employees can acquire services without the risk of a balance bill or out-of-network charges.

"The better reference-based pricing plans out there have a strong patient-advocacy component, which I think is really critical to success," reports Steve Gransbury, president of accident and health at QBE North America. Another key is the efficacy behind advocacy programs, he says.

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RBP represents a strong cost-management technique for both self-funded plans and employees in terms of reining in out-of-pocket expenses that are rising with high-deductible health plans and CDHPs, according to Gransbury. Without patient advocacy, which arm plan participants with the necessary resources to work with providers, he dismisses RBP as simply "a tool in a vacuum."

The power of this arrangement is in promoting clear communication among several stakeholders along the way to efficacy and cost savings. "Patient advocacy works really well when there's a three-party call with a provider, advocate and the plan participant," he observes.

Addressing problem spots

An example of where patient advocacy can make a significant difference in improving outcomes and bending the cost curve is outpatient infusion therapy, or more specifically, dialysis. Those charges tend to be quite high, Gransbury says.

Patient advocates play an indispensable role in explaining re-priced benefit payments under the RBP model to providers who were accustomed to charging much higher amounts under a previous model, he notes.

The thinking is that they also eliminate high anxiety associated with patients receiving a substantial balance bill through this transparent approach and can steer them to the right providers in the first place.

Advocates typically analyze medical and pharmacy claims data, including biometric screening results and self-reported information, and produce a personal profile of each patient, Leibowitz explains. What's particularly helpful is that early recommendations can be made to avoid larger concerns down the road.

A diabetes diagnosis, for instance, would require more than just a routine annual medical exam. The eyes and kidneys also need to be checked alongside a peripheral neuropathy exam and hemoglobin A1C measurement – additional appointments that a patient advocate could set up.

If a health plan member wants to review her maternity coverage, Leibowitz says a health advocate can certainly explain the benefits, but the real value of this service transcends those issues. It's in asking questions about issues that may be hidden from view. For example, did the individual already touch base with an obstetrician if she's pregnant, or are there any high-risk factors that would require fetal maternal health expertise?

"We go to the market with 'empowered health,' which is a collection of data-driven, proactive outreach and intake services that attempts to engage people in the clinical discussion about how to improve their health," he reports.

"The ultimate value of health advocacy is helping people get better care and the best possible medical outcome."

Kelly is well aware of the "full-contact game between medical providers trying to maximize revenue, in our opinion, on the backs of employees," which necessitates a comprehensive approach. His firm offers robust legal representation for employees or dependents who are being pressured by way of a balance bill or collection action from a medical provider.

There has been "a tremendous passivity" on the part of employers in terms of how they pay for health care services, he says, including a lack of investigation into amounts charged for various medical services. What often happens is that they simply turn over these tasks to an administrator or insurance company and step out of the picture.

It's not unusual for ELAP Services to come across a CT scan routinely billed at anywhere from $3,000 to $6,000 and then discounted 30% or 40% when it costs hospitals just $200 to perform. "So we believe that employers not only have the right, but also an obligation to challenge these bills," Kelly exclaims, noting how it's also their fiduciary responsibility to do so.

In the absence of this approach, he laments that employers "have no option but to push more costs down to the employee in the way of out-of-pocket costs or more premium share. So it's kind of like a dog chasing its tail."

Revenue cycle management software platforms lack the data necessary to discern what transpired during each hospital stay, explains Mike Dendy, vice chairman and CEO of AMPS. This makes it impossible for health care payers to determine reasonable charges. He describes hospitals as "the 800-pound gorilla in most communities," afraid to flex their muscle so that patients might pressure their employer to cover large unpaid balances.

"You've got some hospitals who claim to be financially strapped, and I'm sure that's the case," Dendy observes. *"But you've got hospitals making money hand over fist, as well, and they have these protective programs called certificates of need, which basically eliminates all competition that they can have in a specific market. So hospitals are unregulated utilities, for the most part."*

Another problem, he says, is that so-called BUCA plans, third-party administrators and others under the PPO model have no incentive to police self-funded payments. Their focus is simply on securing hospital discounts and collecting per-employee per-month fees from employer groups. PPOs typically overpay by about 30%, which he says RBP can prevent.

Without patient advocacy and RBP, he laments that hospitals will continue to act as creditors collecting grossly overcharged bills, while higher co-pays and deductibles for health plan members will remain as a misguided strategy to mitigate cost increases for employers.

"The value of the advocate is to explain to the hospital or physician, 'here's why you got paid what you got paid and to the member, 'here's how it was calculated and why you're getting balance bills,'" Dendy says.

Transitioning from a traditional PPO involving BUCA plans to RBP is no casual undertaking and requires careful communications for members and providers alike, according to Ed Day, CEO of HST. Patient advocacy represents the centerpiece of this model.

While some firms outsource the patient advocacy component, his provides an in-house service with highly knowledgeable administrators because "it is such a critical function of client retention and persistency."

Noting an increase in fiduciary burden for employer-sponsored retirement plans, Kelly says "it seems to be rather hands-off on the health and welfare side. That's kind of a paradox. We're not sure why that is, but all we can do is urge employers to be more proactive and take a firmer grasp of the reins to managing their plans."

A wise investment

The price of not having patient advocacy in place may be too steep for most health care payers. Any "frictional" costs associated with these services "could be very wise investments to support reference-based pricing," according to Gransbury. "When you're limiting catastrophic claims to 200% or 300% of Medicare, they largely represent a more impactful discount than what the PPO may allow for. As the cost of the claim gets higher, you start to lose the power of the discount if the underlying network contract has outlier provisions," he says.

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When determining any return on investment (ROI) for patient advocacy, results are ultimately benchmarked against control groups. "Because we have the claim data, we know what it costs," Leibowitz explains, "and because we have that total claim data, we can look across and say here's what the impact of that was in medical costs for the employer. So we calculate an ROI based on people that engage with us compared to people that don't."

Although Health Advocate Solutions doesn't outwardly promise specific savings, clients can realize up to 9:1 ROI in some cases. Leibowitz acknowledges "a healthy skepticism" of ROI and believes it's best to focus on delivering better care and improved outcomes, which, of course, can save employers money.

The company applies data and information to employee engagement in a way that's relevant to each individual and works across various communication platforms. Having a telecommunications giant as a parent company allows Health Advocate Solutions to leverage user-friendly technology for everything from automated outbound calls to remind patients about doctor appointments to emails or text messages related to their conditions.

ELAP Services has seen its clients typically reduce their year-over-year overall health care spend by 20% with the help of patient advocacy integrated into the RBP process, or as Kelly describes, "metric-based" pricing. "It's critical that the plan members are supported and advocated for," he explains.

None of the hundreds of thousands of claims Payer Compass has processed was ever litigated because of a transparent approach with medical providers that avoids adversarial communication. It stands in stark contrast to some service providers whom Martin describes as going "nuclear" by having lawyers send threatening letters.

Patient advocacy in conjunction with RBP has saved self-insured employer clients 70% to 74% on average compared to before they had patient advocates in place – savings that can be passed onto health plan members. "Many employers don't even take a premium out of people's checks for these plans, and when they do, it tends to be a much smaller premium," he notes.

Bullish forecast

While patient advocacy programs can serve as a tremendous cost-savings tool for self-insured employers, it's not a standard practice. Martin believes "there's a mindset to overcome," noting how PPOs gradually lost their effectiveness over the past 30 years. "A lot of agreements are still tied to percentage of charges" and simply accepted as a cost of doing business, he explains.

The future of RBP, powered by patient advocacy, looks bright. Day notes that CalPERS, the nation's second-largest health plan behind the federal government's employee benefit plan, has adopted this approach alongside GE, Walmart and Safeway. He sees more of this activity trickling down market from jumbo groups to those with between 500 and 25,000 lives.

Leibowitz expects patient advocacy will extend to the disability and workers' comp areas in the future, as well as behavioral health – noting that there are more than 3 million members of an employee assistance program (EAP) serving his corporate clients.

While paying reasonable charges is a key objective behind patient advocacy, Fey believes there's much more to this approach than meets the eye. "If you're getting the wrong treatment directions half the time, that's really a human-performance issue because you're not getting better and you're spending money," he explains. Misdiagnosis can lead to stress, anxiety and depression – necessitating the involvement of an EAP and more holistic approach.

Over the past 30 years, he has seen most people struggle to navigate the system, "whether it's pharmacy benefits, medical plan design, or the cave of behavioral health." Fey is determined to reposition these elements to mirror more of "a human performance discussion around the enterprise the peak operating performance of the individuals in the enterprise." ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for nearly 30 years.