thekarisgroup®

Patient Advocacy: Effective cost containment members actually want

Consumers want someone in their corner who they can trust to guide them through today's health care mess. And they're willing to pay for it.

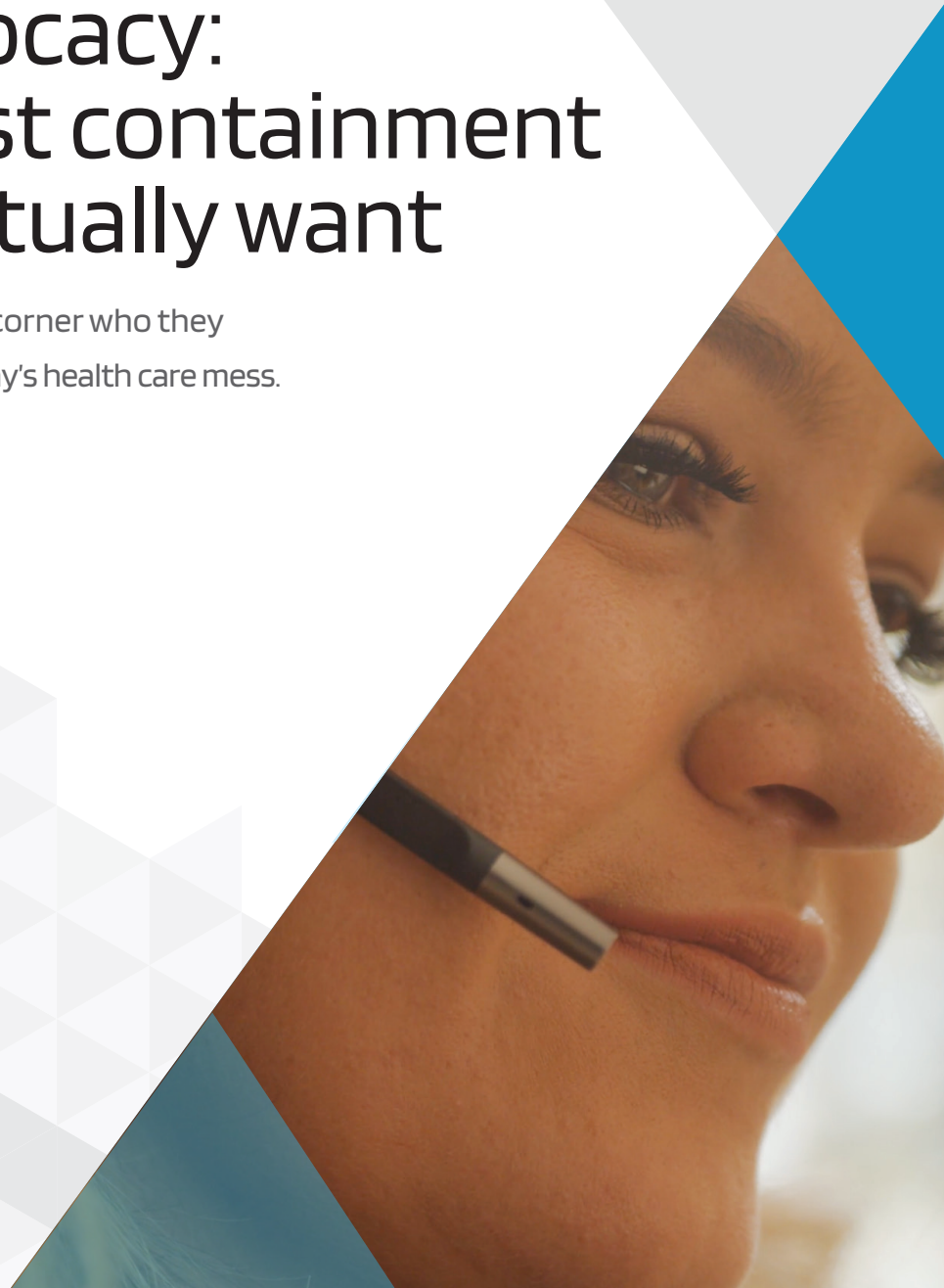


Table of Contents

Is it time to add personalized patient advocacy to your health plan?

The din from politicians, media pundits and health care industry lobbyists about the U.S. health care system is inescapable. It's no wonder. The U.S. spends almost 18% of our gross domestic product (GDP) on health care, the most in the world. Worse, around 30% of that spending can be considered wasteful or unnecessary, impacting both insurers and the insured [1].

1. Big-picture problems, personal impact.

While the U.S health care system clearly needs fixing, the saga of changing an entire nation's approach to deeply complex issues is still being written. It's an important story, but one muddied by politics and diluted by repetition. The dollar amounts are mind-numbing, the stakeholders powerful, and proposed solutions little more than hypothetical, top-down theories beyond the grasp of most individuals who just want quality care without going bankrupt to get it. People like:

Jessica Pell, who went to a hospital emergency room for a cut on her ear. They treated her with a single ice pack and handed her a bill for $5,751 [2].

Scott Kohan, who underwent surgery for a broken jaw at a hospital that was in his carrier's network. But his surgeon wasn't. His share of the bill was $7,924 [2].

Gretchen Liu, who chose to pay the full $40 retail price for a 90-day supply of generic telmisartan out of her pocket—because the previous time she filled it, her insurance copay was $285 [3].

The anecdotal has become endemic

Unfortunately, these true stories are not isolated experiences. Forgotten in the noise about the system's big problems and future solutions are millions of individual plan members or employees and their families—with real medical needs now—who find themselves lost in today's health care maze and, too often, financially devastated as a result.

Patient Advocacy: A bottom-up solution?

"Patient advocacy" is a broad term encompassing a range of services [4], but in its most general sense can be defined as a service or individual who helps patients navigate the complexities of the health care system and who works on their behalf to solve health care-related problems.

Patient advocates are health care problem-solvers.

The idea of patient advocacy is not new; it took hold in America in the 1920s, but its roots can be traced as far back as the 14th Century Ming Dynasty [5]. Today, various advocacy services are offered by insurers and employers (either through or in addition to their health plans), and even provider groups and facilities like hospitals have begun providing patient advocates. In addition, independent patient advocacy (where an individual hires their own, personal advocate) is on the rise [6].

Since patients' choices can directly impact health care costs—and even a "right" choice can still result in quality and cost issues—the concept of equipping plan members and employees with good information, tools, assistance, and guidance seems like a no-brainer for insurers and plan sponsors [7].

Is patient advocacy truly valuable to the individual?

As attractive as the concept of patient advocacy may be to health plans and employers for containing costs, it doesn't work if patients don't participate.

That's why The Karis Group partnered with Nelson Associates to find out if employees and plan members see value in specific patient advocacy services.

In addition, these perceptions of increased value can be linked to higher Net Promoter Scores (NPS) for health plans (which, for employers, may equate to increased employee engagement).

Our research suggests that not only do members highly value these services (when delivered objectively), they're willing to pay extra for them because the relatively low additional cost is more than offset by increased peace of mind and potential dollar savings, which can range into hundreds of thousands of dollars.

2. The Challenge: Health care is *hard*.

The relentless climb of U.S. medical costs, especially in recent years, has prompted plan sponsors and insurers to introduce coverage options that have shifted a substantial share of the financial load onto employees and plan members.

+ High deductible health plans (HDHPs), with their lower premiums in exchange for higher deductibles (and sometimes access to health savings accounts), are specifically designed to remind members they have a "dog in the hunt"—but unless you can compare quality and price ahead of time, how can you be a smarter health care consumer?

+ Even "traditional" plan designs now may include confusing provisions like separate ER deductibles, fewer copays, more restrictive drug formularies and pre-authorization requirements, network pharmacies, etc.

+ HMO and EPO plans have always had stringent network restrictions, but today it's hard to find many health plans of any kind without significant financial penalties for receiving out-of-network care.

+ Plus there are "wild cards" like opaque prescription drug pricing, separate Rx deductibles, in-network facilities providing care from out-of-network physicians, embedded and non-embedded family deductibles, preferred provider tiers, and so many more.

The net result of all these efforts to control costs is an incredibly confused, frustrated and often angry member or employee who can easily make unwise and unnecessarily expensive care decisions.

Symptoms: Lack of understanding, curiosity and trust

The simple, sad fact is that with the myriad plan designs, provisions and restrictions, Americans simply don't know enough about health care to make informed decisions without expert help. For example:

+ They often haven't been educated about even the basics of health care. A PolicyGenius survey of 2,000 consumers revealed 96% of Americans couldn't define basic health care terms, including "deductible," "co-insurance," "co-pay," and "out-of-pocket maximum [8]." Perhaps worse, the same study showed that most who didn't understand these terms actually thought they understood them very well.

+ They often don't make the best choices about where to go for care. The New England Health Institute said 56% of emergency room visits were "totally avoidable." Several studies suggest many of these cases could have been handled in urgent care facilities. In fact, the top three reasons for ER visits in 2019 were chest pains (4.3 million visits), upper respiratory infections (2.5 million) and urinary tract infections (1.5 million) [9]. When the ER is first choice for coughs and UTIs, there's a disconnect.

"...consumers see no safe port, no place where their interests are truly protected..."

+ They don't trust information they get from health care industry players. A 2016 Harris Poll revealed only 16% of U.S. consumers believed health insurers put patients ahead of profits, and only 9% believed pharmaceutical and biotechnology companies did [10]. Said Wendy Salomon, VP of Reputation Management and Public Affairs at Nielsen, "...(when it comes to health care) Consumers see no safe port, no place where their interests are truly protected..."

Causes: Lack of clear direction, unwillingness or inability to engage

In addition to introducing new plan designs, employers and health plans have provided (and continue to provide) information and programs—often multiple programs—designed to help members better manage their health care. These efforts are generally passive or reactive in nature, requiring members to know how (and be willing) to actively access them when needed, understand their capabilities and limitations, and know how to use them. As a result:

+ Their "consumer experience" with health care and benefits is often fragmented and confusing. Simply adding vendors or programs without coordination or someone to help navigate them isn't helpful. A recent survey of more than 300 HR and benefits managers found the biggest challenge for 44% of organizations that work with multiple partners or vendors for benefits is that the experience is disjointed and confusing for employees. And 40% said there is a lack of utilization as a result.

When employees or members are faced with multiple vendors for different aspects of their care, with no clear integration or primary touchpoint for seeking advice or assistance, programs go unused or underutilized [11].

+ Members don't shop around for health care discounts. Worse, they don't ask their current providers if discounts are even available for their treatment. Yet 61% of adults surveyed who asked their doctor for a discount got one [12].

+ Consumers don't properly review their medical bills. Mistakes on medical bills are common. According to Employee Benefits Adviser, up to 80% of bills contain errors. An Equifax audit found that on hospital bills totaling $10,000 or more, the average error was $1,300.

The inevitable outcomes

When members aren't engaged in managing their health care, don't know what to look for, or don't have a trusted source of advice and assistance, it's not all that surprising that their care choices and actions (or inaction) lead to less-positive clinical outcomes and/or higher medical expenses for themselves and their plans. For example:

+ Unnecessary medical services waste $210 billion annually. In a John Hopkins survey of more than 3,000 physicians, respondents said 15 to 30% of medical care delivered is not needed: 22% of prescription medications, 24.9% of medical tests, 11.1% of procedures, and 20.6% of overall medical care [13].

+ Patients typically don't seek second opinions. The combination of the "power of the lab coat" to influence their perceptions and the lack of easily accessible and trustworthy expert help finding alternative providers causes most patients to accept their doctor's initial advice or diagnosis without seeking a second opinion.

Less than 17% of patients seek a second medical opinion after a diagnosis (50% in cases of cancer diagnoses) [14]. Yet the Mayo Clinic reports that as many as 88% of patients who do get a second opinion go home with a new or refined diagnosis, changing their care plan (and potentially their lives). Conversely, only 12% receive confirmation that the original diagnosis was complete and correct.

+ They often choose the wrong providers. The value of having a solid relationship with a quality primary care provider is long established [15]. But when members/employees do select their own providers and care options, they tend to have low levels of satisfaction with the experience.

A 2015 *Advisory Board* study showed that when people selected a primary care physician on their own, they typically give them a Net Promoter Score (NPS) of +3 on a scale from -100 to +100 [16]. (Net Promoter Score, in this context, measures the likelihood of patients to recommend the doctor to a friend, colleague or family member.)

In contrast, the same study shows the experience was dramatically improved (up to 7x better) when members used third-party navigation vendors to help them find healthcare providers. When they used a navigation service, they gave the doctor an NPS of +77. And Net Promoter Scores were in the +80s and +90s when they used third-party vendors to find specialists.

Why is it so difficult to choose well?

Reasons why members and employees often have difficulty choosing a suitable primary care physician (PCP) or specialist include:

+ The sheer number and types of providers who can treat the same illness or condition.

+ Health plans that don't require referrals to specialists leave the patient without guidance.

+ Patients are generally not qualified to objectively judge the quality of a provider's education or training.

+ While online provider reviews have rapidly become very important to patients when choosing a PCP or specialist [16], often these reviews can be incomplete, inaccurate, or misleading for a variety of reasons [17].

3. Patient Advocacy: Changing the status quo

In 2018, 72% of employers surveyed offered patient (or health care) advocacy benefits, services and/or programs to their employees, up from 57% just two years earlier [7]. It's easy to see why. Simply put, when done well, patient advocacy helps contain costs by working on behalf of plan members and employees to solve health care problems.

There are many types and styles of advocacy services. Some have a narrow focus, such as those located in clinical settings, or applications for pricing medical services, or securing second opinions. Some are information-based, some high-tech, others high-touch. Many are offered as part of a health plan through the insurer.

72% of employers surveyed offered patient (or health care) advocacy to their employees.

However, we believe members and their families receive the most value from an integrated suite of *digital + human* personalized advocacy services that provide patients with a single touchpoint for information and expert assistance at every step of their health care journey.

Education

Equipping members with the knowledge to deal with the health care system is valuable, but it's not the total solution for everyone. As the PolicyGenius survey mentioned earlier reveals, most patients still don't understand basic health care terminology [19]. This suggests a more proactive approach is needed—something that helps them avoid the missteps in the first place.

For example, The Karis Group's new HealthPRO service reaches out to each individual member long before a health care event to create a personalized care profile with tools designed to help patients choose high-quality, cost-effective care.

Navigation

Health care navigation services, such as Karis Health Navigator, help members when a health care event is imminent—from finding a suitable PCP, understanding a diagnosis, locating an appropriate specialist and scheduling appointments to choosing a surgical facility, transferring medical records—even pricing procedures and prescriptions in advance. Effective navigation services can play a critical role in helping patients make smart care decisions, even (or especially) when feeling stress or anxiety from a diagnosis or upcoming procedure.

Negotiation

Medical bills are complex, so whether you're looking for errors or negotiating a lower rate with the provider, it helps to understand medical billing and know what to look and ask for. Many patients aren't aware that providers may be willing to negotiate a lower charge. Even fewer patients feel equipped to negotiate effectively, especially when their energies should be focused on healing. A negotiation service can be invaluable to health plans and their members by reducing the cost of medical bills, sometimes significantly. For example, Karis Bill Negotiator services have saved members more than $300 million since 1996, with average out-of-pocket savings for employees of 40-70%.

Benefits for employers and health plans

Done well, patient advocacy services can benefit employers and plans in multiple ways:

+ **Cost containment:** Effective advocacy programs result in better utilization as members become smarter health care consumers, make fewer poor choices, and are steered toward care that combines quality outcomes and lower costs.

+ **Improved employee satisfaction and engagement:** Advocacy can improve satisfaction with employee benefits and the company in general, potentially improving attraction and retention. Likewise, our research shows members of health plans that offer third-party advocacy services are more likely to recommend that plan to others.

+ **Lower workloads on HR staffs:** When employees have access to personalized health advocacy services, they are less likely to call HR or company-sponsored benefit centers with health and insurance concerns.

+ **Fewer HIPPA concerns:** Employers and health plans alike have more insulation from privacy issues when they offer a trusted third-party advocacy service.

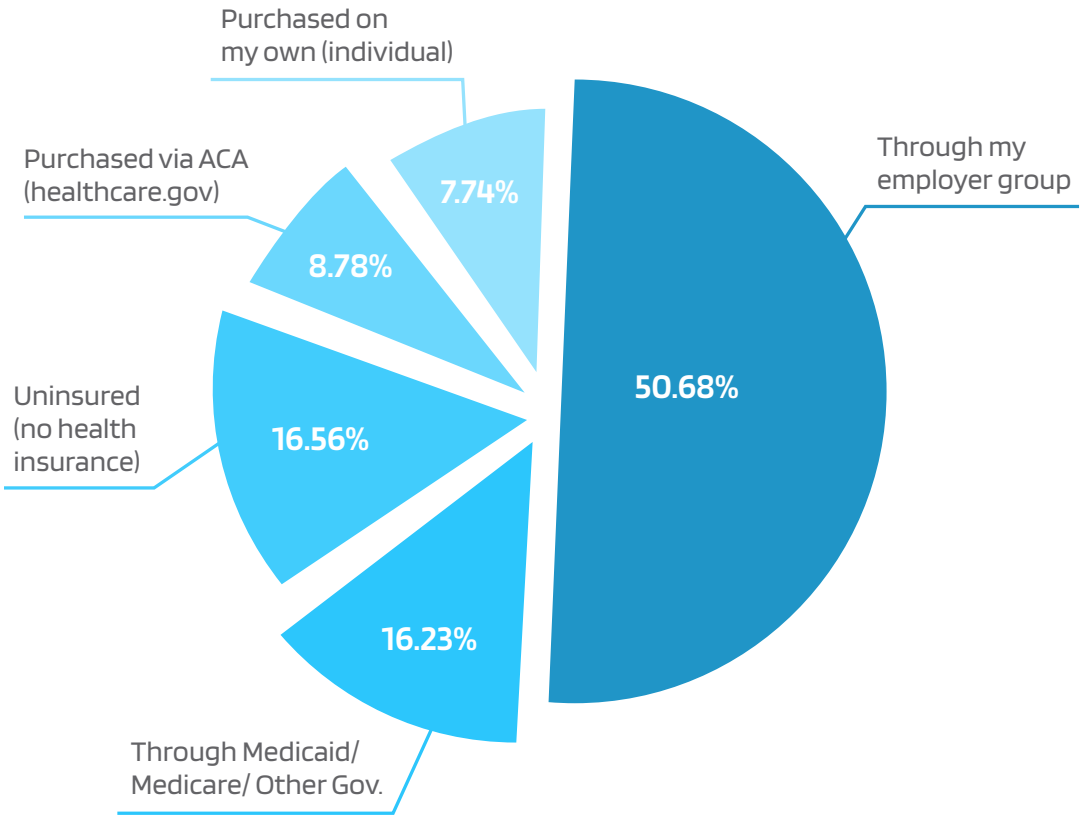
4. The Research: What's the value of patient advocacy?

Costs for patient advocacy services and programs naturally vary based on services provided. But compared to other costs in today's health care environment, and considering the potential savings involved, they're surprisingly reasonable.

However, employers and health plans are understandably reluctant to add any expense, no matter how incremental, to their existing health care costs. But what about members or employees? We know that demand is growing for independent patient advocates hired by individuals [6]. So we wondered if that would translate into a willingness by health plan members or employees to pay extra for these services (either through a premium increase or out-of-pocket)—and how much additional they felt these services were worth.

The study

The Karis Group partnered with Nelson Associates to conduct an original consumer survey of 510 employed adults with health insurance (either group insurance provided by their employer or individually purchased coverage).



The survey was designed to determine how much respondents were willing to pay for patient advocacy services to:

- Find the best provider to match their needs and schedule appointments
- Search local pharmacies to identify the best price for their prescriptions
- Shop for and suggest the best and most cost-effective surgery facility for their needs
- Handle the transfer of their medical records
- Help negotiate their medical bills for lower out-of-pocket expenses

The survey questions included brief descriptions (1–2 sentences) explaining the potential benefits of each of these five advocacy services.

In addition, to help quantify the value to health plans of adding advocacy services, we asked respondents to rate how willing they would be to recommend and promote their health plan if it were to add each of the services as a way of measuring their Net Promoter Scores [21]. (While our study did not specifically measure employee engagement, we believe that NPS is a reasonable analogy.)

We also asked respondents to rank the attributes they found most attractive in advocacy services.

Survey results

Even with minimal explanations about the benefits of each service, 100% of respondents expressed a willingness to pay at least something additional for all five advocacy services. When asked if they'd be willing to pay extra for at least one of the services, 64.6% said they would. In addition, 25% to 40% of respondents said they'd be willing to pay an average between $1.55 and $2.49 per month extra for each service, or an additional $9.63 per month for the five services.

100% willing to pay for all 5 services

64.6% willing to pay for at least one service

Key finding

Of those respondents who indicated which attributes they value most in patient advocacy services, **22% cited objectivity through a neutral advocate company** or service, as opposed to through the insurer. (This response was second only to "free of charge" at 29%.)

This is borne out in additional studies, and a key advantage of objective third-party advocates is that they're not company employees, they know privacy protocols, and employees can confide in them with confidence, knowing it won't get back to their employer [22].

As to whether they would be more willing to recommend or promote their health plan if it added advocacy services:

+ Adding a third-party bill negotiation service led to 17.6% average NPS growth*

+ Adding a provider match/ scheduling service netted an 18% average NPS growth*

+ Adding any of these health care advocacy services resulted in a 16.5% average NPS growth*

*among 38.4% of respondents

5. Conclusion

Through our work helping clients and their members or employees contain health care costs, and through our research on patient advocacy programs, The Karis Group believes more strongly than ever that effective, objective third-party advocacy programs are an essential piece of the U.S. health care jigsaw puzzle.

+ The need for advocacy services is great and growing, due in part to the complexities of today's health care system, opaque pricing and plan designs that put members or employees at ever greater financial risk.

+ Patient advocacy done well can have a significant positive impact on health plans, employers, and their members or employees through improved cost containment, proactive education and outreach programs, effective navigation and negotiation services, and improved access to quality, cost-effective care.

+ Effective, comprehensive advocacy services are not a "do-it-yourself" project. "Advocacy" is premised on trusted fiduciary responsibilities and the greatest value to the individual member or employee comes from having complete faith in their advocate's objectivity.

+ The cost for these services are relatively low, and members or employees are willing to pay more in premiums to cover the cost in exchange for having an industry expert on their side who will do the heavy lifting it takes to lead them through the health care maze.

About The Karis Group

The Karis Group has been untangling healthcare for our clients' members and employees since 1996, when our founder was misled on the cost of his knee surgery and negotiated it down to a fair price. Our compassionate and dedicated professionals provide personalized education and outreach services, individualized guidance tools, and navigation and negotiation solutions that reduce poor choices, frustration, and financial impact. We're setting a course for the future by investing in a technology-driven yet human-focused approach to proactively meet the growing needs of our clients.

To learn more about The Karis Group and our services, please visit www.TheKarisGroup.com.

Appendix

Survey Methodology

Respondents were included only if they had a Group or Individual Healthcare insurance plan.
Purchasing decisions and buying behaviors are made by humans with "bounded rationality" and limited information.

There are very weak correlations and predictive power from attitudinal research, but very strong predictive power by assessing revealed preferences through actual purchasing decisions and behavior (even if only in a simulated purchase).

In this survey we simulated consumer purchasing decision behavior by offering participants a set of alternative features at various prices to determine how many would be willing to pay how much for Patient Advocacy Services.

Survey detail

Policyholder Value Study: Respondent Profile

Bill negotiation (n=468)
39.4% of respondents were willing to pay an additional average monthly premium of +$2.49 for an individual plan and +$6.66 for a family plan

Surgery facility location service (n=452)
31.4% of respondents were willing to pay an additional average monthly premium of +$2.02 for an individual plan and +$5/30 for a family plan

Prescription shopper service (n=394)
30.7% of respondents were willing to pay an additional average monthly premium of +$1.99 for an individual plan and +$5.33 for a family plan

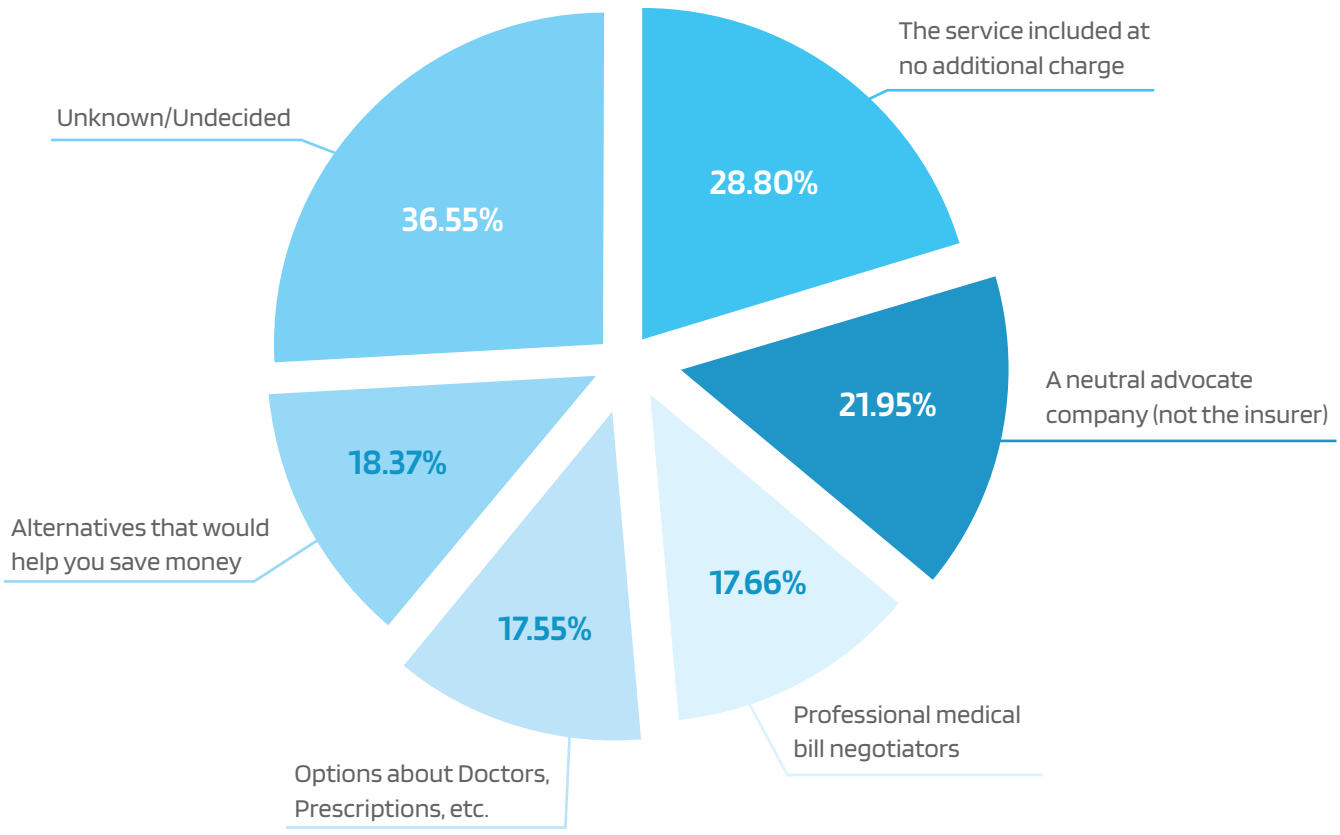
Medical record transfer service (n=389)
25.2% of respondents were willing to pay an additional average monthly premium of +$1.55 for an individual plan and +$4.19 for a family plan

Healthcare provider match/scheduling service (n=381)
24.7% of respondents were willing to pay an additional average monthly premium of +$1.58 for an individual plan and +$4.23 for a family plan

For all five services (n=381)
100% of respondents were willing to pay an additional average monthly premium of +$0.07 monthly for an individual plan and +$0.23 for a family plan

The 25% to 40% of respondents showing a willingness to pay for the five Patient Advocacy Services were, on average, willing to pay +$9.63 per month in additional premium for all five services.

Most Important Components of a Healthcare Advocacy Service (n=340)



Source: Nelson Associates July 2018
Behavioral Economics Online Survey

References

1. "Waste in the US Health Care System: Estimated Costs and Potential for Savings" Shrank WH, Rogstad TL, Parekh N., *Journal of American Medical Association*, 2019.
https://karis.cc/39sLj0L

2. "American Health Care Horror Stories: An Incomplete Inventory" Fran Quigley, *truthout.org*, 2019
https://karis.cc/2SbALxb

3. "Why a patient paid a $285 copay for a $40 drug" Megan Thompson, *PBS NewsHour*, 2019
https://karis.cc/2UwMKqq

4. "What's a Patient Advocate – and Should You Have One?" Mia Taylor, *The Simple Dollar*, 2019
https://karis.cc/3bgNoyx

5. "Patient Advocacy History, Evolution and Impact on Health" Ana Rita Gonzalez, *Juniper Online Journal of Public Health*, 2018
https://karis.cc/2tJw2JG

6. "Patient advocates for hire attracting more attention" Steven Ross Johnson, *Modern Healthcare*, 2019
https://karis.cc/2Uz6Wbb

7. "How care advocacy could lower medical cost growth in 2019" Ingrid Stiver, *PWC*, 2019
https://karis.cc/2SrA4yx

8. "4 basic health insurance terms 96% of Americans don't understand" *Policygenius*, 2018
https://karis.cc/31yHGTW

9. "Emergency Rooms vs. Urgent Care Centers" *debt.org*, 2019
https://karis.cc/3897xVb

10. "Harris Poll: Only Nine Percent of U.S. Consumers Believe Pharma and Biotechnology Put Patients over Profits; Only 16 Percent Believe Health Insurers Do" *The Harris Poll*, 2016
https://karis.cc/389q03N

11. "Driving Benefits Engagement: Strategies to Optimize Employee Health and Well-Being Programs" Health Advocate, 2017
https://karis.cc/38aFG6O

12. *The Healthcare Survival Guide*. Martin Rosen and Abbie Leibowitz, MD, HealthAdvocate Publishing, Inc., 2009

13. "Why clients should care about medical billing errors" Miles Varn, *Employee Benefits Adviser*, 2018
https://karis.cc/37ahznu

14. "In survey, doctors say unneeded medical care is common, driven by fear of malpractice" Chanapa Tantibanchachai, *John Hopkins University HUB*, 2017
https://karis.cc/3blaX9d

15. "Patient-Initiated Second Opinions: Systematic Review of Characteristics and Impact on Diagnosis, Treatment, and Satisfaction" Velma L. Payne, PhD, Hardeep Singh, MD, MPH, Ashley N.D. Meyer, PhD, Lewis Levy, MD, David Harrison, MD, Mark L. Graber, MD, *Mayo Clinic Proceedings*, 2014
https://karis.cc/2S7kA3J

16. "The value of second opinions demonstrated in study" Mayo Clinic, *ScienceDaily*, 2017
https://karis.cc/2S7ny8i

17. "The Impact of Primary Care: A Focused Review" Leiyu Shi, *US National Library of Medicine National Institutes of Health*, 2012
https://karis.cc/38aIxg2

18. "Is it fair to compare physicians' Net Promoter Score to Apple's?" Emily Zuehlke, *Advisory Board*, 2015
https://karis.cc/38jWWXH

19. "Patients Trust Online Reviews As Much As Doctor Recommendations (And Other Shocking Facts About Transparency In Healthcare)" Andrew Ibbotson, *Health IT Outcomes*, 2018
https://karis.cc/39i3ENG

20. "Why You Can't Always Rely on Online Doctor Ratings" Jeneen Interlandi, *Consumer Reports*, 2017
https://karis.cc/2SrSa3t

21. "Net Promoter Score: How to Measure Customer Loyalty" Katharine Paljug, *Business News Daily*, 2017
https://karis.cc/377HZ9t

22. "Patient Advocacy Organizations: Institutional Conflicts of Interest, Trust, and Trustworthiness" Susannah L. Rose, Ph.D, *US National Library of Medicine National Institutes of Health*, 2013
https://karis.cc/375jrOj


thekarisgroup®