Teaching Case

Too Much of a Good Thing: User Leadership at TPAC

Brett Connelly
connelbe@miamioh.edu

Tashia Dalton
daltontm@miamioh.edu

Derrick Murphy
murphyd1@miamioh.edu

Daniel Rosales
rosaledh@miamioh.edu

Daniel Sudlow
sudlowdj@miamioh.edu

Douglas Havelka
douglas.havelka@miamioh.edu

Information Systems & Analytics
Miami University
Oxford, Ohio, 45255, USA

Abstract

TPAC is a small third party health claims business that was seeking avenues for revenue growth and opportunities to increase efficiency. One course of action that management selected to achieve these goals was a change in the software application used to process claims. The new application was adopted to increase the speed and accuracy of claims processing. Given the enthusiastic motivation of the claims department manager, Susie Jeffer, and the importance of the new application to the Claims department; Susie was selected to lead the project. The case details the challenges the organization faced by selecting a leader for this critical project that had no project leadership experience or IT background. The implications of this decision on the business operations are presented and then solutions to the situation are explored. This case is targeted for an MBA IT management or strategy course; but could be used in an introductory course, a systems development course, or a senior-level undergraduate IS/T capstone course.

Keywords: teaching case, systems selection, project management, leadership

1. INTRODUCTION

It was a Monday morning in late October, a chill wind was in the air. Susie Jeffer leaned back in her chair, reflecting that her over-priced Chai tea latte and dry scone were not going to be enough to get her through the difficult meeting scheduled in the next hour with the company president.

Recently hired as a claims manager, Susie Jeffer had joined TPAC after 15 years in the healthcare industry. TPAC is a small third party health claims business located in El Paso, Texas. The company recently hired a new President with over 20 years' experience from a large third party health claims competitor and was planning to grow the business. To facilitate this growth, a review of the IT (information technology) infrastructure had been performed and a recommendation made to update the claims processing software application to lower costs which would allow TPAC to compete with its larger competitors and attract new customers.

The previous claims processing system did not have necessary capabilities to meet client needs. TPAC had become known for its flexibility in customizing benefit plan designs to help clients provide their employees an affordable benefit package that fit within the company's budget.

The previous system did not have the ability to auto adjudicate claims without manual intervention. Auto-adjudication is the ability to approve (or deny) a claim based on the facts of the claim and the benefits plan, without needing a human to validate it. Being a small company, it was difficult for TPAC to expand business without a claims system that could auto adjudicate claims. The primary benefit of having a system that requires less manual intervention is to allow the Benefit Administrators (claims processors) the ability to focus on clients' higher value needs; such as reports, claim adjustments, phone calls and other necessary tasks. The current system was restricting TPAC's potential to capture a larger market.

From Jeffer's perspective, she had done her level best to implement the President's new vision for TPAC. It had taken great courage volunteering to take responsibility for the implementation of the new IT system without any prior background in IT. Further, she had been the sole TPAC associate to receive the training on the new system! Further still, the training had only lasted two weeks – she was doing her best with what she'd been given. As far as she was concerned, her best had been stellar.

However, Jeffer was still fuming over senior management's recent criticism concerning the lack of programming she had put into the new system. If more capabilities were to be wrung out of the system, she would need a team to implement additional upgrades.

Jeffer's upcoming meeting with company president Sandy Davis had her worried, since Davis had become critical of Jeffer's handling of the implementation. Davis unabashedly voiced the opinion that TPAC now found itself back in the same spot they had been with the old system: it needed manual intervention, it was error prone, and it slowed claims turnaround. As she sipped at her Chai tea, Jeffer contemplated the long hours of work ahead. How will her employees adapt? Will her customers see a benefit? Or, will the company lose customers rather than grow the business?

2. THE ROLE OF A TPA

The traditional value stream (Exhibit 1) within the health care industry was for an employer to find a health care insurance company like Blue Cross, Anthem, or United Health Care to provide health benefits, assume payment risk, and process claims and payments for employees and service providers. This value chain came at a very expensive premium cost to the employer. As health care costs continue to rise, employers have been searching for ways to reduce the cost of employee healthcare.

A recent change in the value stream (Exhibit 2) in the administration of health care for employees has been for the employer to assume all payment risk as a self-insured company and contract a Third Party Administrator (TPA) that will handle the health claims and payments.

The TPA is neither the insurer nor the insured. Their task is to handle the administration of an agreed upon benefits plan that includes the processing, adjudication, and negotiation of claims. They also provide record keeping and general maintenance of the plan. The only difference in a TPA role versus a fully insured carrier is the TPA doesn't fund the payment of the claims; rather, the payment of claims is funded by the client.

The two main drivers for the use of third party administrators is lowering health care costs and

better plan design for company specific employee demographics and needs. Savings are significant because the company only pays for the administration of actual claim costs versus an insurance benefits' offerings that may or may not be used. Insurance company administration of claims is also much higher than a specialized TPA (whose focus is only on creating and administering the plan).

The TPA's have specialized software and processes that allow for timely and less expensive alternatives than the insurance companies. Typical cost savings a company can expect when moving from a fully insured plan to a self-insured plan with a TPA can be seen in Exhibit 3. An added benefit to the TPA business model is that it shelters the company from any concern of HIPAA (privacy) violations.

3. TPA PROCESSES

The claims system is programmed to process claims according to the plan design. One of the major benefits of being self-insured is that each client (employer) can customize their healthcare plan based on the needs of their company and their budget. This means clients are not sold "cookie cutter" plans that may include features that are not needed or may not include features that are very desirable. As each client's plan is designed uniquely for them, the claims processing system needs to be a robust system without plan setup limitations.

Every client has a different plan design which includes items such as:

- Eligibility - Determines the requirements of the employer regarding the number of hours an employee must work to receive benefits.
- Dependent Age.
- Timely Filing - Each employer determines the length of time within which a claim must be filed in order to be considered for processing (standard 1 year).
- Plan Design - This includes deductible, copays, and coinsurance
- Benefit Structure – this includes the definition of services that are covered or excluded and defines visit maximums on necessary services (physical, occupational, and speech therapy; and chiropractic services).

The goal of the system is to auto-adjudicate as many claims as possible, thus limiting the need for manual intervention while maintaining the quality guidelines. Auto-adjudication simply involves checking each of the claims for required information and restrictions and determining the amounts to be paid.

Also, the system needs to be able to accommodate any client's "reasonable" request. The more adaptive the system, the more able the claims administrator is to retain clients and increase future business. Providing quality healthcare for employees is expensive; therefore, employers need to rely on innovative TPA companies to assist in cost containment solutions.

4. NEW CLAIMS SOFTWARE APPLICATION SELECTION PROCESS

As TPAC's new president, Sandy Davis' first decision was to upgrade the IT infrastructure; and specifically the claims processing application. Davis convinced the board that a new system was necessary to achieve revenue growth and capture top-tier clients. A new application would increase flexibility for creating benefit plans and offer scalability allowing TPAC to grow by capturing larger volume clients.

With the prior system, each claim was manually processed by a Benefits Administrator. Since there was no auto processing of claims, the old system allowed room for more errors and inconsistency. There were instances where claims for the same procedure were handled differently: one claim was entirely covered, another partially covered, and a third denied. Ultimately, this slowed the process of claims processing and inflated the claims error percentage.

Davis tasked the Executive Management Team to narrow the choices for the new system. An industry consultant was retained to assist the Executive Management Team in exploring the alternative software solutions that would adequately fit their needs. Following weeks of debate, the options for the new application had been narrowed down to two: TreatFirst's Excaliber system and BigHealth's Benefitica IT suite.

The system finalists were very comparable. They both met the requirements for benefit plan

design flexibility and allowed for Consumer Driven Service products to be linked to each client rather than requiring a separate application to administer Health Savings Accounts, Flexible Spending Accounts, and COBRA (COBRA is health insurance that must be provided to employees when they are terminated).

TreatFirst's main disadvantage was that Excaliber took more time to set-up each benefit plan. However, this was mainly true because the application allowed the benefit plan design to be more detailed, thus increasing the accuracy rate of claims processing as well as tightening up measures to increase the auto adjudication rate. With the Excaliber system, TPAC could place more clients on the system without having to hire more Benefits Administrators to handle the additional work load.

On the other hand, BigHealth's Benefitica application was easier to use when building the benefit plans. There was less coding to be done which resulted in less time setting up a plan. The Benefitica system still increased efficiencies and also had a higher auto-adjudication rate. However, the integrated details in TreatFirst's Excaliber were marketed as having a higher accuracy rate.

The Executive Team invited the five Team Leads from each department to test the applications. After each lead was given a demonstration of both systems' capabilities, the Executive Team interviewed them for feedback. Team Leads cast their vote on which application they thought would best deliver functionality and performance.

Despite their desire to get broad-based input from all of the departments that would be affected by the new application, the voting was rigged. Although each Team Lead had their opportunity to vote, the voting wasn't kept confidential. Since the Executive Management Team had already cast their votes, the decision came down to the five Team Leads. Jeffer, the Claims Lead made no qualms about her choice. (Jeffer would have primary oversight of the application, it is a claims application and she is the claims manager.) She cajoled the four other leads to vote for her choice. The persuasion worked, as they felt pressured to vote for her preferred system.

The voting over, Davis revealed that TPAC would pursue Jeffer's choice: the BigHealth system. Feeling confident by her win and eager for a promotion, Jeffer volunteered to take on the configuration and implementation of the Benefitica IT application. Seeing potential in Jeffer, Davis tasked her with creating a roadmap for configuration and implementation of the new software.

5. TRAINING AND IMPLEMENTATION

The following week, Jeffer was on a plane to New York to receive training at BigHealth's corporate office. She received training on all of Benefitica's functionality, as well as how to configure the software to best fit TPAC's customized needs. Two weeks later, on the plane ride back to El Paso, Jeffer quickly sketched a roadmap for master data conversion, training, and implementation of Benefitica IT.

Concerning an implementation plan, Jeffer ranked the clients on a schedule based on their size (A-D, A being largest, D being smallest), and planned to convert the larger clients first hoping to realize improvements in productivity as quickly as possible. The conversion process involved duplicating all the unique attributes for each client's Summary Plan Description into a unique plan profile in Benefitica IT.

Jeffer was excited from her training and ready to get started on data conversion. She began the process of taking the Summary Plan Description, the guidelines of each client's plan, and translating the data into Benefitica's plan profile manager. After working 70 hours the first week, Jeffer' enthusiasm quickly waned as she realized the magnitude of the workload.

As the Claims department manager, Jeffer oversaw 10 Benefit Administrators (BA). She changed her conversion strategy, delegating the benefit plan set-up and data entry load to the BAs. Over the next week she scheduled several lunch-and-learns to familiarize the BAs with this additional responsibility.

Each BA was tasked with completing benefit plan profiles for clients according to the client's personalized Summary Plan Description. As each plan profile consisted of numerous attributes and settings the data entry was time consuming and prone to user error. The process was rushed because the number of clients assigned to each Benefits Administrator was roughly 15 to 1, with daily work still needing to be completed. As accuracy was vital, any incorrect setups resulted in claims being processed incorrectly.

6. PROBLEMS ARISE

Problems started to arise when the first batch of clients; i.e. Group A, the largest clients TPAC had, went live on Benefitica. Each client transferred to the new system without incident; however, the process was so quick that there was not enough time to iron out any issues before the next client went live.

With the new claims processing system, the auto adjudication rate was expected to increase to at least 90%. When a claim is auto-adjudicated through the system, the claim should be processed and paid correctly with no errors. If a claim doesn't meet all the requirements to go through the adjudication process, then it is pended for manual intervention.

During the benefit plan set-up these tight measures were not configured, which allowed more claims to adjudicate through the system and led to more errors. The industry accuracy rate was 96%, a metric shared with every prospective or current client. The increase in errors meant an increase in manual intervention for claims adjustment. It also resulted in increased calls from members, clients, and providers concerning incorrect claim processing.

Because of the extra errors and an already heavy workload, the BAs grew agitated with claims manager Susie Jeffer. Since the Benefits Administrators had daily contact with the clients and their employees, this required each BA to take extra time out of the day to explain to upset clients why there were errors.

This created friction internally from senior management all the way through the company. David, a Senior Benefits Administrator, could not understand why after so much time and effort there were so many issues and increased work. The new claims application was presented to his team as a change that would make their lives easier. Instead, the team received an increased work load which required more and more overtime. When Susie approached David about the amount of overtime the team was using, David could not control his emotions. David could not understand why Susie did not comprehend the volume of errors and problems with the new system. As David continued to document the errors and issues, Susie did not believe these errors were due to the new application and denied that they were due to any type of implementation error. She flatly stated these were not system related errors. Instead of reviewing the issue log, Susie ignored the errors. Instead she continued to forge ahead with the remaining client benefit plans. She was adamant that her project plan would meet the original deadlines.

Due to the deteriorating climate in the claims department, the Director of Operations decided it was time to take part in the weekly BA meetings. She hoped to drill down to the underlying problem and to understand what was happening from the source. Although she quickly realized the issue was related to the implementation of the new application; she added fuel to the fire by defending Susie. The team was furious.

7. THE FALLOUT

The Director of Operations began "mentoring" Susie to help fix issues, but glossed over the gravity of the situation to Senior Leadership to protect Susie's job (and her own reputation as well, she had been a supporter of Susie as a promising manager). Although system implementation was completed after nine months, issues were still being addressed and claim adjustment rates were at an all-time high. This had ramifications throughout the entire company. Phone calls for adjustments were increasing, Account Management was receiving requests for meetings by unsatisfied clients, and the overall morale was very poor.

In spite of it all, TPAC managed to retain its current clients and actually added new ones. As the company grew, the need for additional IT support was recognized and a new system administrator was hired. Jeff, the new system administrator, spent 6 months working with Susie to learn the system. After that time, Jeff was still not confident in her ability to manage, maintain, and enhance the system's performance.

Jeff finally convinced the Director of Operations to fund him for Benefitica training. He received training for four weeks. From this, he realized that there were many capabilities of the system that were not being used. In fact, the way TPAC was currently using the new application was not an improvement from the old system. Website functionality for employee self-service was not being utilized to its full capacity to allow clients to enroll employees online. This lack of functionality was creating problems on the eligibility side. While claims should be processed at a 90% auto-adjudication rate with a 98% accuracy rate, instead they were experiencing rates under 50% with 60% accuracy; this was

occurring primarily because the employee enrollments were not accurate and up-to-date.

These circumstances and other considerations led the Director of Operations to resign. A new Director of Operations, Rita, was hired. Rita had prior experience with another TPA and was very familiar with the new claims processing application. Her knowledge and expertise appeared to be extremely valuable to TPAC.

She was shocked when she discovered the issues TPAC was having with the software. She could not believe TPAC was even surviving with the way the system was functioning. She immediately brought this knowledge to the Senior Management team.

In addition, Rita tried to mentor and counsel Susie. She "confronted" Susie with all of the issues and her response (or lack of response) to them. Despite all this, Susie remained confident and felt she had not made any serious mistakes; except selecting the wrong system.

Given Rita's goal to make substantial improvements in claims processing, specifically improving the auto-adjudication and accuracy rates, she worked directly with Jeff. Susie was still on the project management team, but they had tasked her with leading the BAs to improve daily operations rather than any application related tasks.

8. SEEKING SOLUTIONS

Rita was under pressure from leadership to terminate Susie. Although unsure, Rita felt this was a bit of scapegoating by upper management. She thought they were looking for someone to blame for the unsuccessful project to alleviate some of the clients' concerns. And Susie did appear to be a bit clueless at this point.

Rita didn't feel as if she was in the role long enough to make the decision to terminate Susie. Rita contemplated how to handle the situation, she decided to task Jeff to go back through each client setup and do a thorough audit of each plan to ensure they were setup accurately.

Rita spent the weekend in her office trying to weigh all of her options. The busy season with open enrollment was just around the corner and a decision needed to be made Monday morning. Some of the questions Rita pondered as she prepared for the meeting with Susie on Monday included the following questions:

- Should Susie be fired? Was she really a bad employee or was she just put into a role that wasn't compatible for her?
- How could Rita justify this action to leadership without letting Susie go? Should she?
- At this point, Susie was still on the project team and making changes to the software, she was one of the only people in the company with deeper knowledge of how the software worked. Should Susie remain on the project? Should she be moved? What role should have?
- Should Rita be concerned that there is a risk to the company that Susie will sabotage other areas of the company out of spite and anger? What should she do to mitigate this risk?

Editor's Note:

This paper was selected for inclusion in the journal as the EDSIGCon 2015 Best Case. The acceptance rate is typically 10% for this category of cases based on blind reviews from six or more peers.

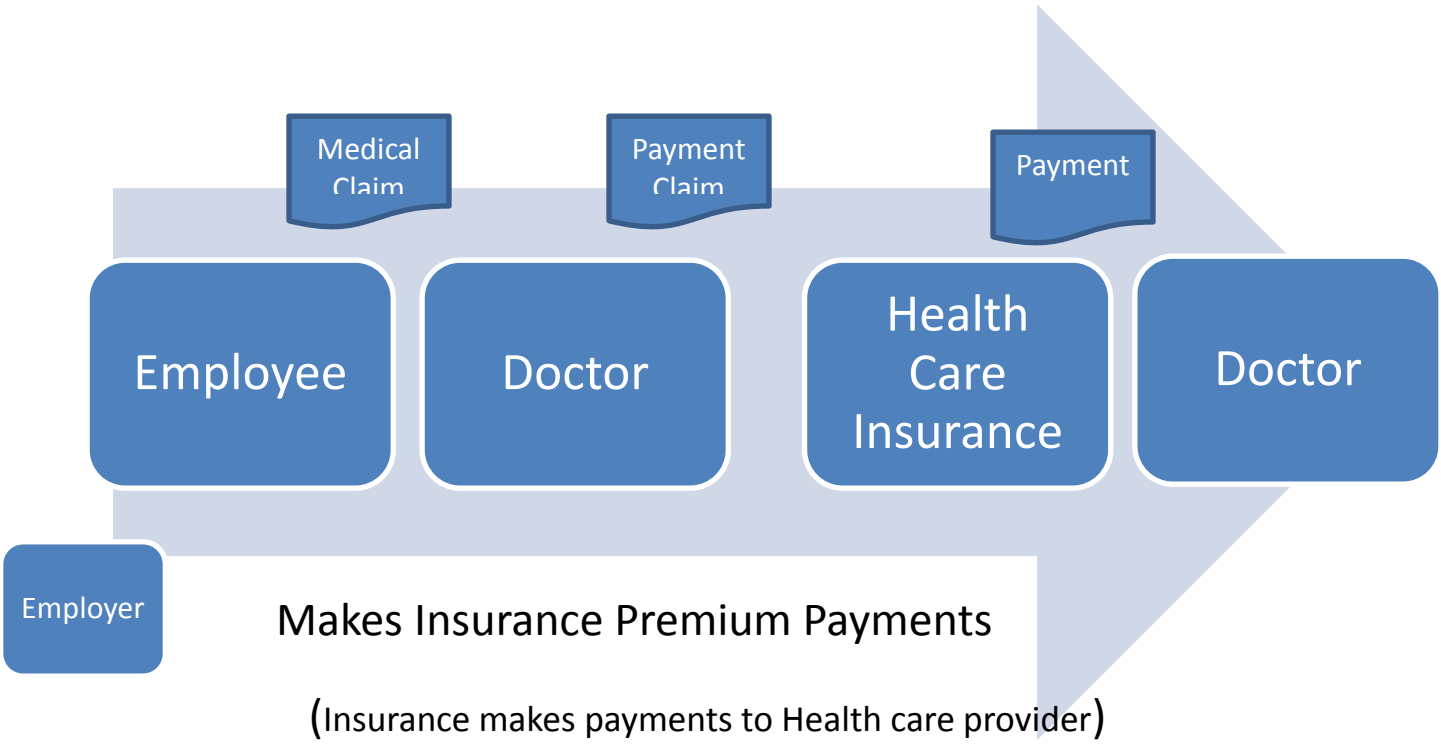
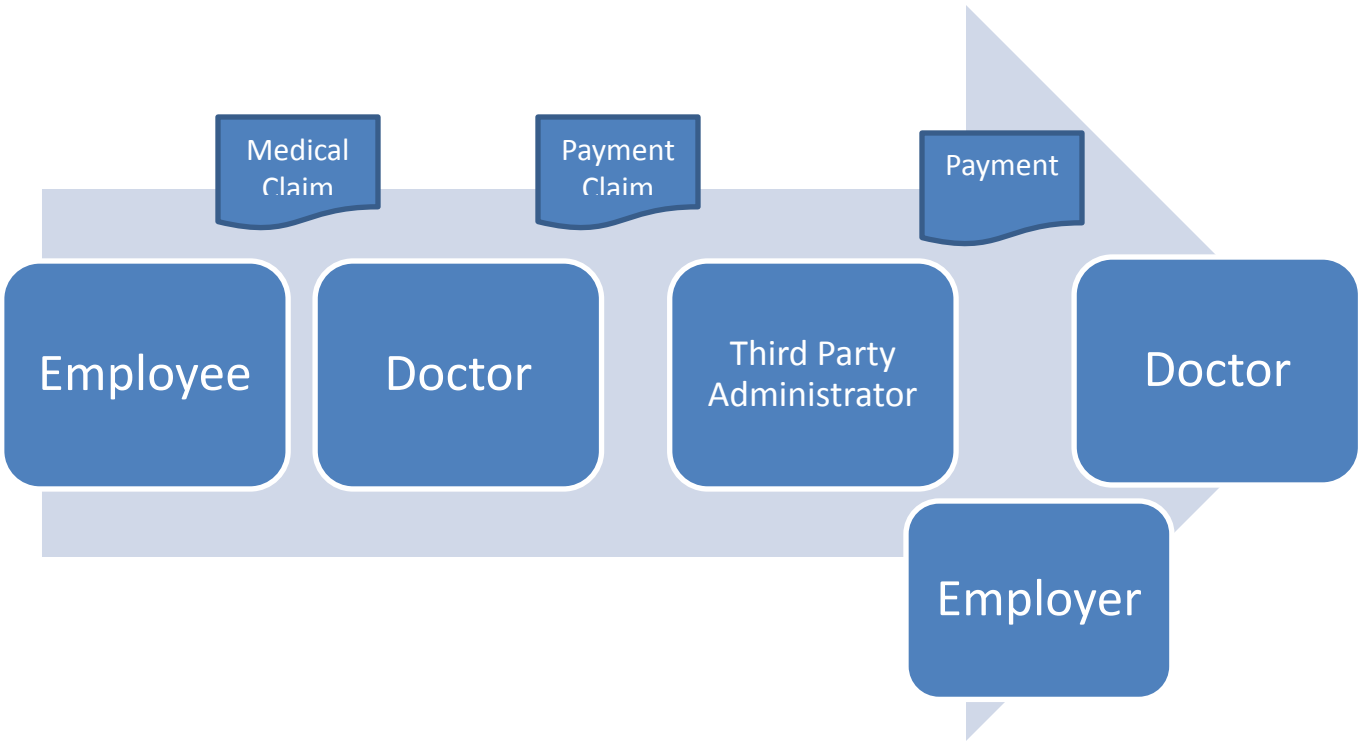


Exhibit 1 – Traditional Value Stream



Employer Pays TPA for claims administration

(Employers makes payments to Health care provider)

Exhibit 2 – New Value Stream: TPA replacing Health Care Insurance

Exhibit 3 – Potential savings with a TPA