Administrative Simplification: An overview

Webinar for the Health Policy Board
June 1, 2010
Administrative Simplification: What is it?
A definition of administrative simplification

“Administrative simplification” refers to efforts to reduce the complexity of health insurance administrative and financial transactions between payers and providers.
The goal of administrative simplification

The primary goal of administrative simplification is to reduce insurance administrative costs by standardizing, eliminating, or automating health insurance administrative and financial transactions.
Insurance administration – Its components and its cost
What are the components of health insurance administration?

- **Insurer activities**
  - Marketing
  - Underwriting and enrolling
  - Billing policyholders
  - Provider relations
  - Claims processing
  - Management of benefits
  - Regulatory compliance
  - Profit

- **Provider activities**
  - Marketing
  - Admitting and check-in
  - Claims submission, billing, and posting
  - Management of care
  - Regulatory compliance
  - Profit
What activities are addressed by administrative simplification efforts?

- Insurance enrollment and billing
- Provider credentialing and contracting, including price negotiation
- Verification of enrollment, benefits, and enrollee cost sharing
- Claims processing and payment
- Prior authorization and utilization review
Which are not addressed by administrative simplification efforts?

• Administrative simplification efforts generally do not address the costs of marketing, underwriting, and profit.
How much do US health plans spend on administration?

- US spending for administration is higher as a percentage of national health care spending than for other advanced industrial countries
- Medicare spends 2-3% on administration
- Private insurers spend, on average, 12% of premium for administration
- In Oregon, the major insurers spend 10-15% of premium on administration
How much of private health insurance premiums is spent to conduct financial and administrative transactions?

- Health plans = 2-4% of premium (directly)
- Health plans = 13-19% of premium (indirectly)--reported as claims cost because
  - Physicians spend 10-15% of revenue
  - Hospitals spend 7-11% of revenue
Key Terms
Transaction Terms

• **Claim:** A request for reimbursement (or bill) sent by a provider to a plan.

• **Claims attachment:** A document sent by a provider to a plan in support of a claim, such as a chart note, discharge summary, or a remittance advice or explanation of benefits from the health plan that is the primary payer on a claim.

• **Claim Status Inquiry:** Request from a provider to a plan seeking to know whether a claim has been accepted for payment and if not, what’s going on.
More Transaction Terms....

- **Remittance Advice**: A communication sent explaining to the provider the payments made by the plan for a particular period of time. It will list the claims that are being paid and uses a coded format to explain how and why the payment amounts differ from the amount billed.

- **Eligibility Inquiry**: Request from a provider to a plan seeking to know if a patient is enrolled in a plan and if so, the plan’s benefits and cost-sharing rules.
Administrative Simplification Terms

- **HIPAA transaction**: A transaction for which HIPAA required HHS to develop standards for electronic information exchange: Claims (or encounter information), claims attachments, remittance advice, eligibility inquiry and response, prior authorization and referral, claims status inquiry and response, health plan enrollment/disenrollment, health plan premium payments, and first report of injury (worker’s compensation).

- **HIPAA standard**: An HHS rule adopting a technical standard for electronic health financial and administrative transactions, including detailed standardized code sets.
More Administrative Simplification Terms

- **Implementation Guide**: Part of each HIPAA standard that provides detailed instructions and explains the choices the standard leaves to trading partners.

- **Companion Guides**: Documents specifying how the standards and implementation guides for each HIPAA transaction will be used between particular trading partners. Generally, companion guides are issued by plans. Providers must comply with a different guide when doing business with each plan.

- **Operating Rules**: A new term, introduced by the 2010 federal reform law, defined as “necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
Past Administrative Simplification Efforts
International and national simplification efforts

- World Health Organization adopted diagnosis codes
- American Medical Association developed procedure codes
- Medicare developed claim forms
- Medicare developed billing methodologies
  - RBRVUs for physician payment
  - DRGs for inpatient hospital payment
- All of these have been very widely adopted (more limited adoption of Medicare billing methodologies)
Congressional action on administrative simplification

- The Health Insurance Portability and Accountability Act (HIPAA) – 1996
  - Directed the US Department of Health and Human Services to:
    - Develop a coding manual
    - Adopt standard codes and methods for conducting certain transactions electronically
  - Required any provider or health insurer conducting transactions electronically to use the standard codes and methods beginning in 2002.

- The Administrative Simplification Extension Act – 2001
  - Extended the date for complying with the requirement to use standard codes and methods for electronic transactions
  - Required most Medicare providers to submit claims electronically.
HHS implementation of HIPAA

- HHS adopted standards, including “implementation guides” for:
  - Health plan enrollment/disenrollment
  - Claims
  - Remittance Advice
  - Eligibility Inquiry/Response
  - Claims Status Inquiry/Response
  - Referral and prior authorization.

- HHS has never the adopted standards HIPAA directed the agency to adopt for:
  - Claims attachments
  - First report of injury.
State-level efforts on administrative simplification

- Utah (1993) – Providers and payers created an electronic post office to handle insurance transactions electronically; they adopted uniform standards pre-HIPAA.
- Minnesota (2007) – Legislature directed the state to develop and adopt uniform companion guides for three key transactions and required all providers and all payers to do the three transactions electronically.
- Washington (2009) – Legislature set deadlines for a private entity to develop uniform processes for several transactions and achieve voluntary adoption of them; instructed Insurance Commissioner to act if private sector fails. No requirement for providers or payers to do business electronically.
Focus on Minnesota

- **Uniform companion guides** were adopted for claims, remittance advice and eligibility inquiry transactions.
- A **state-convened industry work group** that has been engaged in simplification activity for 20 years developed the three companion guides.
- **Expert leadership** for the work groups made sure the guides complied with the HIPAA standards and with emerging voluntary industry standards.
- The state **Department of Health** adopted the guides by administrative rule.
- **The state moved quickly**: A companion guide was developed and a rule adopted for eligibility inquiries less than 8 months after the legislation passed. The claims guide was in place after another six months and the remittance advice after another six months.
Focus on Minnesota

- A year after each guide was adopted everyone – all group payers, all providers, and all clearinghouses -- was required to give up manual processes and do the transaction electronically, following the uniform guide.
- **Minnesota has updated each of the original guides** to comply with the version of the HIPAA standards that takes effect January 1, 2012.
- **Results:** 95% of claims are now submitted electronically.
Patient Protection and Affordable Care Act

- Sets deadlines for HHS to adopt standards for electronic funds transfer, claims attachments, and first notice of injury
- Sets deadlines for HHS to adopt operating rules for HIPAA transactions
- Requires periodic HHS review of standards
- Requires HHS to make standards more prescriptive
- Requires providers dealing with Medicare to accept electronic funds transfer and electronic payment remittance advice by 1/1/2014
- Strengthens enforcement provisions.
The limits of past efforts

• HIPAA was expected to push the healthcare industry into the electronic age and generate billions in savings.

• In reality, the industry is still substantially non-electronic because
  – The HIPAA standards did not fully standardize administrative transactions.
  – There has not been widespread adoption of electronic business methods.
What is the potential for cost savings from administrative simplification efforts?
Potential for savings from increased administrative simplification

• Projected national savings of $20-200 billion/year for full electronic adoption

• Oregon estimates
  – $222 million per year
    (OAHHS-commissioned report)
  – ~$100 million per year
    (OHPR Administrative Simplification Work Group)
Who stands to gain from administrative simplification savings?

- Clinics
  - Those with higher visit volumes may experience greatest savings
- Insurers
- Hospitals
  - Lesser gains due to lower claims volume
  - Lesser gains due to increased automation already
- Purchasers and consumers could gain if insurance premiums go down
How ready are Oregon stakeholders for administrative simplification efforts?
OHPR surveyed three groups in early 2010:

- Payers by face-to-face interviews
- Hospitals by electronic survey
- Physician practices, including ambulatory surgery centers, by electronic survey
Many providers submit claims electronically

Percentage of claims that are submitted electronically

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<th>Hospitals</th>
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<td>Less than 25 percent</td>
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The rate of electronic claims submission in private insurance lags behind public programs

- Private insurers - 76-81%
- DMAP (fee-for-service) – 90%
- Medicare – 97%
There is broad provider consensus about the barriers to increased electronic claims submission.

Most important:
• Paper claims attachment requirements
• Health plans that do not accept electronic claims

Other:
• Software or clearinghouse difficulties interfere
• About 5% of physician practices prefer paper claims
Reducing paper claims saves money.

Health plan estimates for savings from processing electronic claims instead of paper claims range from $1.76 to $3.00 per claim.
Most providers make some use of the HIPAA electronic eligibility verification transaction, but less efficient telephone and website-checking persists.

- Checking insurer websites is the most commonly used method to verify eligibility
- For clinics, the second most common method is a telephone call
- For hospitals, the second most common method is a HIPAA electronic inquiry
There is broad provider consensus about the key barriers to increased use of electronic inquiries.

Most important:

- Insurers do not provide enough information electronically

Other:

- Plans do not provide responses fast enough
- Software or clearinghouse difficulties interfere
- About a third of clinics say they’d rather talk to a person
Provider telephone inquiries cost a lot for providers and payers

- One plan reports spending $1.22 per member per month for provider phone calls
- Work group participating clinics estimate that telephone inquiries cost providers about $2.50 more than electronic inquiries per claim.
Few providers use HIPAA standard transactions except for claims submission and eligibility inquiries

- Most hospitals but few physician practices accept an electronic remittance advice
- Even fewer physician practices use the electronic remittance to eliminate costly manual payment posting
- Few providers accept electronic funds transfer for their payments
- Virtually no providers use electronic inquiries to determine the status of a claim
- Virtually no providers make referral or prior authorization requests using a HIPAA standard electronic transaction
Oregon stakeholders are ready for state-level action on administrative simplification
While recognizing the barriers, Oregon providers and plans are open to greater use of electronic transactions

• Plans say
  – Greater use of electronic transactions is the key to administrative savings

• Providers say
  – Standardizing is the key to adoption of electronic transactions
Administrative simplification now will help providers qualify for federal health information exchange incentives

- Medicare and Medicaid incentive programs pay providers more for electronic information exchange
- To qualify providers must submit 80% of their claims electronically and do electronic eligibility inquiries for 80% of their patients
- To get maximum incentives providers need to reach these goals in 2012
Providers and plans see a role for the state in administrative simplification

• Voluntary efforts have mixed success.
• Substantial savings could be achieved if everyone did business using electronic processes.
• The state can eliminate barriers to success
  – Providing the uniformity providers need
  – Assuring payers of the increased use of electronic processes that assures them of a return on their investment in uniformity.