

Bankers Eager to Streamline Health Transactions

BY ERIK L. GOLDMAN
Contributing Writer

WASHINGTON — With health savings accounts serving as a point of entry, banks and other financial institutions are rapidly moving into the health care sector, and bankers believe they have much to offer in streamlining health care transactions and bringing greater efficiency to the medical world.

In this era of e-commerce, it is difficult to remember a time when even the simplest personal financial transactions involved paper and required direct interactions with tellers, a time when cash was not available 24/7, and a world where all of one's personal financial information wasn't simply a few mouse-clicks away. In terms of the digitization of health care financing, we are still in that paper-based era, and many people feel distrust for electronic health care management in the same way they felt distrust for electronic banking when it was first introduced.

But bankers engaged in health care believe we're on the cusp of rapid change. Over the next decade, broader adoption of health savings accounts (HSAs) coupled with interoperable personal health records systems on the patient side, and wider use of electronic medical records on the physician side, will bring health care in line with nearly all other industries in terms of maximal use of electronic information exchange.

James S. Gandolfo, senior vice president of PFPC, a division of PNC Financial Services, and chairman of the American Bankers' Association's HSA Council, told attendees at the fifth annual World Health Care Congress that banks' involvement in health care could be profoundly transformational.

For one, banks can provide interoperable and widely accepted technology platforms, something the health care sector has yet to develop on its own. Banks are also very tightly regulated and standardized; they have exhaustive experience conducting rapid and high-volume data ex-

change in a secure environment; they provide multiple but interrelated services for millions of people.

As an industry, health care has lagged far behind other industries in terms of information technology investments. Mr. Gandolfo estimated that about \$3,000/worker per year is spent on technology advances in the health care sector, while about \$7,000/worker per year is spent by other private sector industries, and about \$15,000/worker per year is spent in the banking industry.

He said that he strongly believes it is time for the health care sector to embrace the technology developed by the banking world, and he anticipates it won't be long before we routinely see card-based health care transactions, real-time information exchange, and real-time financial transaction settlements.

According to Chad Wilkins, CEO of OptumHealth Bank, the growth of health savings accounts is a major driver of change, and a strong magnet for banks and other financial service firms eyeing the health care sector.

Mr. Wilkins estimated that currently, financial services companies hold about \$3.2 billion in HSAs, in 2.2 million accounts that cover health care for around 6.5 million Americans. According to a survey by the industry group America's Health Insurance Plans, 27% of individuals who selected HSAs were previously uninsured.

Bankers like Mr. Wilkins and Mr. Gandolfo want to see those numbers grow. "The biggest issue is education. We need to educate the market, educate consumers, educate policy makers, and educate employers," Mr. Wilkins said.

"Once employers get on board with HSAs, you need to help them roll out and implement them. You need good decision-support tools. If you do it right, you see a dramatic increase in the number of people choosing HSAs, and the amount of money going in. It should all

be as simple as dealing with your 401(k)," he asserted.

One of the primary virtues of banking technology is its capacity to eliminate paper-based transactions, something health care desperately needs to do, Mr. Wilkins said. "Ninety-five percent of current payments to providers and explanations of benefits are still done on paper. That's crazy! It's a staggering amount of paper, and much of this can be computerized."

He estimated that it costs banks about \$1 per paper check or provider remittance advice form, roughly \$30 for each voided and reissued paper check, and about \$5 per phone call to see what's wrong in a given transaction. Universal electronic claims could save up to \$35 billion for health care providers and \$1 billion for health care plans.

Mr. Gandolfo said savings on this order are very real. A large health care provider group that implemented PNC's E-Health-care platform realized \$2.9 million in annual cost avoidance, and 64% time savings in its accounts receivables. Electronic funds transfers cut the average time from claims submission to payment by 43%, from 49 days down to 28 days. The average time to make claims adjustments improved by 29%, and automated matching of payments streamlined the accounts-receivable closeout process.

That sounds promising, right? So why aren't electronic health care transactions the rule instead of the exception? Mr. Gandolfo and Mr. Wilkins both stated that as a nation, we're moving in that direction, but there are some hurdles: Most doctors' offices are not yet electronically enabled; HSA adoption is still fairly low; and most of all, there's a lack of interoperability among all the various health IT systems. "We need a solid, common infrastructure to do this on a wide scale, and we're very, very far from that right now," Mr. Wilkins said. ■

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Global Health Evaluation Highlights Top System Performers

BY JANE M. ANDERSON
Contributing Writer

WASHINGTON — Analysis of other countries' health care systems has pointed out what might work—and what won't work—in efforts to reform the U.S. health care system.

At the annual meeting of the American College of Physicians, ACP senior vice president of governmental affairs and public policy Robert Doherty outlined seven key lessons the college learned from health care systems around the globe:

► **Lesson No. 1.** Global budgets and price controls can restrain costs, but they can also lead to negative consequences. Canada, Germany, New Zealand, Taiwan, and the United Kingdom all use global budgets, Mr. Doherty said. In the United Kingdom, for example, annual per capita health expenditures totaled \$2,546 in 2004 versus \$6,012 in the United States that year.

Nevertheless, global budgets do not provide incentives for improved efficiency unless the annual expense budget is reasonable and the target region is small enough to motivate individual providers to avoid the overuse of services, he said.

► **Lesson No. 2.** Primary care is the foundation of high-performing systems. Societal investment in medical education, as found in France, Germany, and the United Kingdom, can help achieve a well-

trained workforce that has the right proportion of primary care physicians and specialists and is large enough to ensure access, he said.

Many countries finance medical school education with public funds, so students pay little (as in the Netherlands) or no (as in Australia, Canada, France, Germany, and Japan) tuition and typically are responsible only for books and fees, the ACP reported earlier this year in a position paper, "High-Performance Health Care System with Universal Access."

In contrast, the average U.S. tuition in 2005 was \$20,370 for public medical schools and \$38,190 at private medical schools, according to the paper. As a result, 85% of graduating medical students begin their careers with substantial debts. In 2005, the average debt was \$105,000 for graduates of public institutions and \$135,000 for those who attended private institutions.

"Rising educational debt influences physician career choices and is one of the factors that discourage medical students from choosing a career in primary care," the ACP position paper noted.

► **Lesson No. 3.** High-performing systems encourage patients to be prudent purchasers and to engage in healthy behavior, Mr. Doherty said. "Patients need to have some stake in the system themselves," he said. For example, in Belgium,

France, Japan, New Zealand, and Switzerland, patients share costs with copayment schedules based on income, and that can help restrain costs while ensuring that poorer individuals have access, he said.

In addition, incentives to encourage personal responsibility—such as those found in Australia, Belgium, Japan, and other countries—can be effective in influencing healthy behaviors, improving health outcomes, and creating responsible utilization, without punishing people who fail to adopt recommended behaviors or lifestyles, he said.

► **Lesson No. 4.** The best payment systems recognize the value of care coordinated by primary care doctors, Mr. Doherty said. Effective payment systems provide adequate payment for primary care services, create incentives for quality improvement and reporting (as in Belgium and the United Kingdom), recognize geographic or local payment differences (as in Canada, Denmark, Germany, and the United Kingdom), and provide incentives for care coordination (as in Denmark and the Netherlands), he said.

► **Lesson No. 5.** High-performing systems measure their own performance. Countries such as Australia, New Zealand, and the United Kingdom, along with the U.S. Veterans Health Administration, have implemented performance measures linked to quality, he said.

► **Lesson No. 6.** High-performing systems invest in health information technology, and have uniform billing and lower administrative costs, Mr. Doherty said. The adoption of uniform billing and electronic processing of claims—as has been done in Germany, Canada, and Taiwan, among others—improves efficiency and reduces administrative expenses, he said.

Meanwhile, an interoperable health information infrastructure can enable physicians to obtain instantaneous information at the point of medical decision making and can enhance electronic communications among treating health professionals, he said. Denmark, Taiwan, and the Netherlands have interoperable health information infrastructures that incorporate decision-support tools, according to the ACP's position paper. "Systems like these will enable physicians to obtain instantaneous information at the point of medical decision making and will enhance electronic communications among physicians, hospitals, pharmacies, diagnostic testing laboratories, and patients."

► **Lesson No. 7.** High-performing systems invest in research and comparative effectiveness.

Many other countries that have national health insurance programs, such as the United Kingdom and Australia, perform evidence-based evaluations of new drugs and technology, the position paper noted. ■