Banks Set to Push Use of Electronic 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. It is hard to imagine that at the advent of electronic banking, it was a scary prospect for many people.

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 exchange in a secure environment; they provide multiple but interrelated services for millions of people. Banking technology has given ordinary people far greater control over their financial lives.

"Banks provide established rules for information exchange, and worldwide standardization. That's why your American ATM card and credit card work when you're traveling in Italy," Mr. Gandolfo said.

PNC Financial Services, which has assets of roughly $90.7 billion and $58.7 billion in total deposits, is the eighth largest treasury management group in the country. It is moving steadily into health care, positioning itself as a health care financial clearinghouse serving 1,200 corporate clients, including Medicare and Medicaid programs, Blue Cross/Blue Shield plans, commercial insurance carriers, and pharmacy benefits managers.

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.

'The biggest issue is education. We need to educate the market, educate consumers, educate policy makers, and educate employers.'

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. "It is still new, but employees are starting to take advantage of HSAs."

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)."

OptumHealth Bank is piloting a new HSA debit card that links to a user's personal health record and facilitates transactions for both patient and physician. The "OptumHealth Bank Mastercard" gives real-time access to benefits information, as well as funds. It essentially eliminates claims forms and the attendant processing. Doctors are paid right away and no longer have to wait 60 days for reimbursement.

Both Mr. Wilkins and Mr. Gandolfo said they and others in the health care banking community vigorously oppose proposed federal legislation that would mandate new HSA expenditure substantiation rules. They contend that new regulations would only add costs, create complications, and slow the widespread adoption of HSAs.

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-Healthcare 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. ■

Employers and Employees Are Slow to Start Using HSAs

BY ERIK L. GOLDMAN
Contributing Writer

WASHINGTON — Health savings accounts and other forms of tax-deferred, consumer-driven health care financing options have captured the fancy of many policy makers, but such options have met with a lukewarm welcome among American employers and the people who work for them.

According to data from Forrester Research Inc., an independent technology and market research company, between 8 million and 9 million Americans were enrolled in a health savings account (HSA) or other tax-deferred plan as of June 2007, with 4.5 million new enrollees in 2007 alone.

But consumer awareness of these options is still very low. A recent study by the Visa Corporation indicated that only 35% of all Americans have even heard of HSAs, and only 14% expressed any interest in starting one.

That is likely to change as HSAs prove their worth, Elizabeth Bierbower, vice president of product innovation for Humana Inc., said at the fifth annual World Health Care Congress. She pointed out that 5 years after the introduction of health maintenance organizations (HMOs), combined enrollment in all existing plans was only 5.5 million. That changed quickly, once major employers became convinced—for better or for worse—that HMOs would save them money. Ms. Bierbower predicted a similar trajectory for HSAs.

Diamond Management & Technology Consultants, an industry consulting company, projects that by 2010 employees and their employers will have put over $75 billion in assets into HSAs. Last year, employer contributions to HSAs already were up over 50% from the previous year.

Some companies are taking a very proactive role in pushing HSAs, especially for lower and middle-income workers. Ms. Bierbower said Humana has been a strong HSA advocate for its employees. For those making under $50,000 annually, Humana will contribute $6 for every $1 an employee contributes to an HSA. "[The ratio is] lower if your salary is higher, but there's still a big incentive to do this. We try to encourage long-term thinking."

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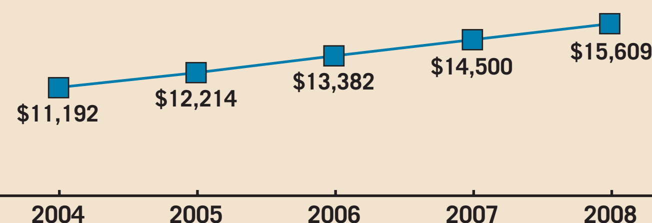
DATA WATCH

Total Health Care Spending for a Family of Four Is Increasing



Note: Based on the Milliman Medical Index, for estimated average costs including employer and employee health insurance premiums, using claims from millions of members.
Source: Milliman

ELSEVIER GLOBAL MEDICAL NEWS

Aetna Defends Its System For Rating Physicians

BY ALICIA AULT
Associate Editor, Practice Trends

SAN FRANCISCO — Speaking at the insurance industry's annual meeting, an Aetna executive defended the company's performance-based physician networks, saying that they were a way to keep costs down and to let patients know which physicians offered the best and most cost-effective care.

Dr. Gerald Bishop, senior medical director for Aetna's West division, spoke at the AHIP Institute, at a conference sponsored by America's Health Insurance Plans.

Preferred provider networks have been the subject of legal challenges around the country, most recently in Massachusetts and Connecticut. Physicians have claimed that the networks use inappropriate methodology to rate their performance.

In 2007, New York Attorney General Andrew Cuomo struck a settlement with several insurers in which they agreed to publicly disclose rating methods and how much of the ratings is based on cost, and to retain an independent monitoring board to report on compliance. Aetna was one of the first insurers to sign on to that settlement, and has continued to comply, Dr. Bishop said.

He noted, for instance, that Aetna reviews and updates its provider list every 2 years and notifies each physician in writing if there has been any change in his or her status. Physicians have the opportunity to appeal if there is an error—before any data are made public, he said.

The company also encourages physicians to submit any relevant information from medical records if they have a question about the rating.

Aetna first began developing its Aexcel network in 2002, Dr. Bishop said. The goal was to mitigate rising costs, ensure patient access to specialists, and find a way to recognize the variations in costs and practices in each individual market, he said. The company found that 12 specialties represented 70% of spending on specialists and 50% of the overall spending: cardiology, cardiothoracic surgery, gastroenterology, general surgery, neurology, neurosurgery, obstetrics/gynecology, orthopedics, otolaryngology, plastic surgery, urology, and vascular surgery.

When considering which physicians are eligible for the network, Aetna looks at the number of Aetna cases managed over a 3-year period (there was a 20-case minimum). The company also uses nationally recognized performance measures to gauge clinical performance. Physicians who score statistically significantly below their peers are excluded.

The company also uses the Episode Treatment Group methodology to evaluate 3 years of claims for cost and utilization patterns. A physician is considered efficient if his or her score is greater than the mean for that specialty and that market, Dr. Bishop said.

The Aexcel network now exists in 35 markets, covering 670,000 members. Aetna members in most, though not all, those areas can log onto a secure patient Web site and see costs for various procedures and information on why his or her physician has been designated a preferred provider in the network.

Dr. Bishop said that Aetna has determined that physicians in the Aexcel network typically perform 1%-8% more efficiently than their peers. Each client could save up to 4% of annual claim costs if all its covered workers used the network, he said.

Although some physicians have been unhappy with the designations, "amazingly few physicians balk at this," Dr. Bishop said. ■

Patient Charter Sets Ground Rules for Physician Ratings

BY MARY ELLEN SCHNEIDER
New York Bureau

Under an agreement among physicians, consumers, employers, and large insurers, some health plans have agreed to have their physician rating systems audited by independent experts.

The announcement comes after physicians around the country have questioned the methods used by health plans to produce the physician performance ratings for consumers.

Under the voluntary agreement, health plans would disclose their rating methods. In addition, physicians would have a chance to review their performance data and challenge it prior to publication.

"Having that transparency is a huge change," said Dr. Douglas Henley, executive vice president of the American Academy of Family Physicians, which is supporting the agreement, known as the Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs.

Giving physicians a chance to ensure that the data are accurate makes the process fair, he said.

It's also beneficial for consumers who will be able to better rely on the information provided by their health plan, Dr. Henley said.

The project was led by the Consumer-Purchaser Disclosure Project, a coalition of consumer, labor, and employer organizations that support publicly reported health performance information.

Other principles of the Patient Charter state that the measures should aim to assess whether care is safe, timely, effective, equitable, and patient centered. The measures used should also be based on national standards, preferably those endorsed by the National Quality Forum.

The principles of the Patient Charter do not apply to pure cost-comparison or shopping tools.

This agreement provides a foundation for physicians to build on, said Dr. David C. Dale, president of the American College of Physicians, another supporter.

Now when any health plan establishes a physician rating system, physicians can ask whether it is standardized and how it stacks up against the requirements of the Patient Charter, he said.

The Patient Charter also has the support of the American Medical Association, the American College of Cardiology, and the American College of Surgeons.

And some heavy hitters in the insurance industry have agreed to abide by the principles of the charter, including trade group America's Health Insurance Plans (AHIP), as well as Aetna, Cigna, UnitedHealthcare, and WellPoint.

Other health plans are likely to follow suit, said Susan Pisano, AHIP spokeswoman. Third-party review of rating systems and allowing physicians to review and challenge data before they become public will likely become the industry standard, she said.

"We believe strongly that consumers both want and need good information on health care quality," Ms. Pisano commented.

Now that the Patient Charter has laid down the ground rules for how clinical performance measures should be used, the next step is to ensure that physician ratings accurately reflect all the care given, because patients are generally scattered across multiple health plans. Ms. Pisano said the AHIP Foundation is studying how to aggregate data from across different plans to provide a full picture of physician quality. ■

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That, she said, is something grossly lacking in this country. People are simply not saving money, especially for health care needs, and they're in for a rude awakening as they reach retirement age. "Most people do not budget for health care, and they don't understand their cost-sharing levels. People do not understand that Medicare does not cover everything."

Many baby boomers and Gen Xers will not be able to retire comfortably because they have not saved any money to do so. According to research from the Employee Benefit Research Institute, a majority of near retirees has already spent 95% of their preretirement income. The majority of workers aged 45-55 years have less than $50,000 in savings.

With copayments, pharmacy costs, and out-of-pocket expenses on the rise, even people with relatively generous health plans are finding that they still come up short. A Kaiser Family Foundation survey in 2006 showed that 29% of families reported that one or more members had difficulty paying medical bills.

Doctors often bear the brunt of Americans' lack of planning for health care expenses, Ms. Bierbower said. In a Humana survey of consumer attitudes, researchers found that many Americans are quite willing to leave their physicians holding the bag, in the form of unpaid bills. "They tell us that health care providers are the last ones they will pay. They say things like, 'We know the doctor will take $10 a month.' They perceive that doctors are rich and don't really need the money."

Most people do not budget for health care, don't understand their cost-sharing levels, and don't understand that Medicare does not cover everything.

She added that people are much more inclined to ignore a doctor's bills than a hospital's, for the simple reason that hospitals tend to pursue their payments more aggressively and they can hurt peoples' credit ratings, something they perceive that individual doctors don't do.

"We have to work with our employees and consumers to change this attitude. Doctors need to get paid," Ms. Bierbower stressed.

She said Humana, and many other insurance carriers like Aetna, WellChoice/WellPoint, UnitedHealth Group, Kaiser Permanente, and Great-West have begun offering health care lines of credit to help people cover their out of pocket expenses, copayments, or gaps in existing coverage. The line of credit strategy is also a good option in conjunction with HSAs, to help cover sudden large expenses or as a stopgap in cases in which patients have exhausted their HSA savings.

Humana's line-of-credit card is activated at the time of need, and can only be used to pay credentialed health care providers. The charges are interest free for 6 months. "We're not trying to encourage more credit card debt," Ms. Bierbower said.

Advocates of HSAs and other forms of consumer-driven coverage say that one of the primary virtues of these plans is that they push the end-user of health care services to become more cost conscious, and presumably more judicious, in their health care choices. In practice, this seems to be borne out.

A McKinsey survey showed that people enrolled in HSAs or other consumer-driven plans were 50% more likely to ask about overall costs of health care services, and 100% more likely to ask about drug costs, compared with people in traditional health care plans.

Similarly, a Blue Cross Blue Shield Association study showed that 33% of HSA enrollees asked about prescription costs, compared with only 18% of enrollees in traditional plans. Of those in HSAs, 20% asked about the costs of physician visits, versus 14% of those who have traditional insurance. ■