Employees, Employers Are Slow to Start Using HSAs

BY ERIK L. GOLDMAN
Contributing Writer

WASHINGTON — Although health savings accounts and other forms of tax-deferred, consumer-driven health care financing options have captured the fancy of policy makers, employers and employees have been reticent about embracing them.

As of June 2007, between 8 million and 9 million Americans were enrolled in a health savings account (HSA) or other tax-deferred plan, with 4.5 million new enrollees in 2007 alone, according to data from Forrester Research Inc., an independent technology and market research company. But consumer awareness of these options remains 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 a health care congress sponsored by the Wall Street Journal and CNBC. 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 after major employers were convinced that HMOs would save them money. Ms. Bierbower predicted a similar trajectory for HSAs.

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."

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, said Ms. Bierbower, often bear the brunt of Americans' lack of planning for health care expenses. 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.

She said that people are more inclined to ignore a doctor's bills than a hospital's, because hospitals pursue their payments more aggressively and can hurt peoples' credit ratings, something they think doctors don't do.

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. ■

Banking Industry Rules May Guide Use of Electronic Records

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 terms of the digitization of health care financing, we are still in a 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 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 World Health Care Congress attendees 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. 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," said Mr. Gandolfo.

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 currently 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. 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.

The health care congress was sponsored by the Wall Street Journal and CNBC. ■

Physician Survey: Aetna Deemed Fastest, Most Accurate Payer

BY ALICIA AULT
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Aetna has taken over from Cigna as the fastest and most accurate national insurer when it comes to paying physicians, according to the third annual ranking of payer performance by one of the nation's largest physician management companies.

Cigna achieved the top rank in 2006, and Aetna was No. 2, having moved up from the fourth spot in the 2005 survey by AthenaHealth.

The 2007 data are based on 30 million charge lines collected by AthenaHealth, and cover 137 national, regional, and government payers and 12,000 medical providers. The company, which is based in Watertown, Mass., collected almost $3 billion for its 980 physician clients in 2007.

According to the company, several trends were apparent in the data. Payers have moved to make Web portals more available to physicians, and they've become more proactive about contacting physicians with guideline changes. This has resulted in an almost 3% drop in the number of days that claims are in accounts receivable, at least for regional payers.

Claims denial and resubmission rates increased, however, partly due to problems implementing the new National Provider Identifier number required by Medicare. The full impact of that transition may not be felt until this year, according to AthenaHealth.

After Aetna and Cigna, the top performers were Humana, Medicare Part B, UnitedHealth Group, WellPoint, Coventry Health Care, and Champus Tricare. Humana and Medicare were the top two payers in 2005; United, Wellpoint, Coventry, and Champus have held steady.

"We commend Aetna for their progress in improving what should be any insurer's core competency: paying insurance claims accurately and promptly," said Dr. William F. Jessee, president and CEO of the Medical Group Management Association, in a statement.

Rankings are calculated by scores given to performance in seven areas. If a payer paid quickly and fully, it tended to receive a higher ranking overall. Fifty-eight percent of the score came from days in accounts receivable (DAR), first pass resolve rate, and percentage of billed charges deemed the patient's responsibility.

Physicians have a greater collections burden when payers ask patients to foot more of the bill. There was a 19% increase in patient liability in 2006, but it only rose 0.4% in 2007. Increased availability of real-time claims adjudication has helped cut the physician collection burden, according to AthenaHealth.

Aetna's DAR was 26.9 days, compared with 32.6 for Cigna, and 35.7 for Coventry, which holds the No. 8 overall position. Blue Cross Blue Shield of Rhode Island had the lowest DAR for the second year in a row, at 15.8 days. Denial rate is also an important metric used in the ranking. Aetna had the lowest denial rate among national payers, at about 6%. The highest denial rate—38%—was at Health Choice Arizona. The lowest denial rate overall was 3.17%, at Blue Cross Blue Shield of Rhode Island. ■

The rankings are posted at www.athenapayerview.com.