



UnitedHealth Group®

# Health Care Cost Containment – How Technology Can Cut Red Tape and Simplify Health Care Administration

UnitedHealth Center for Health Reform & Modernization  
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# Health Care Cost Containment – How Technology Can Cut Red Tape

## Introduction

America is not getting good value for the \$2.6 trillion it spends on health care. Too few people have access to high quality care - and yet there is too much waste. Today the nation is once again grappling with how to respond.

UnitedHealth Group supports the goal of universal health care coverage, believing it is best achieved as part of fundamental modernization of how care is delivered. So we accept our responsibility to contribute innovative ideas and options that would enable this to become reality.

UnitedHealth's Center for Health Reform & Modernization therefore recently published *Working Paper 1: Federal Health care Cost Containment – How in Practice Can it be Done?* It identified \$540 billion in potential medical cost savings to the Federal government over the next decade. These were based on applying to traditional Medicare some of the well-tested techniques we as a company use in funding and managing the care of over 70 million Americans. They were not an exhaustive list of the programs we run, or the ideas we have for how to reduce cost growth. They were intended as an initial, constructive, contribution to the debate - aiming to show that "it can be done."

## What this new Working Paper adds

Where our first working paper focused on Federal savings in medical costs, this second working paper is a companion document that identifies practical ways in which technology can save money by modernizing the administrative and transactional aspects of health care. Its focus is on savings across the health care system as a whole – savings that will accrue to physicians, hospitals and payers, and to consumers, employers and taxpayers.

Through twelve building blocks we identify administrative savings opportunities of \$332 billion in national health expenditure over the next decade. These savings would be likely to benefit families and employers through lower health care costs. As importantly, they would simplify the lives of patients, and eliminate much frustration on the part of doctors and hospitals.

Of these \$332 billion in administrative savings, we estimate that approximately 50 percent would accrue to providers (physicians and hospitals), 20 percent directly to government in its role as a health care payer (through Medicare and Medicaid), and 30 percent to commercial payers. (In the options that follow, the combined government and health plan savings are identified as "payer" savings.)

However there are a variety of mechanisms by which the federal government could capture a larger share of the savings, should it so wish. It would first need to set a deadline by which many of the new system-wide standards and processes would take effect. For maximum effect, the new requirements would need to cover all hospitals, physician offices, health plans and all public payers. Once the new processes had taken effect, the resulting administrative savings could help offset the subsidy cost of health care coverage expansions for the newly insured, and the government might also take account of expected overall productivity gains in setting Medicare and Medicaid provider payments. There are also other possible mechanisms that government could use to capture more of the savings. But whether it does so or not, we believe these changes make sense, and need to be adopted comprehensively.

## **Basis of savings estimates**

These proposals derive from our experience - not just as a large payer and care management organization, but as one of the largest health care technology companies in the United States. UnitedHealth Group's 12,000 technology professionals oversee 30 terabytes of health care data and invest seven million hours annually in application development. In funding and arranging \$115 billion of health care we interact with over 5000 hospitals and 650,000 physicians across the country. Each year our technology systems process 60 billion transactions and support 82 million calls, routed to 20,000 customer service agents.

The ideas in this document are supportive of industry-wide approaches to administrative simplification being advanced by AHIP. This working paper draws on the distinctive experience and insights of UnitedHealth Group particularly regarding likely savings impacts and "real world" implementation issues. While not intended as a comprehensive list of options, we believe the twelve approaches identified here are sufficiently detailed to permit reasonable savings estimates. Where individual options are interdependent or potentially overlap, we have sought to net-out possibly duplicative savings estimates.

In addition to these administrative savings, they would create substantial medical cost savings. Only a subset of them are identified in this paper, and none of them are included in the \$332 billion figure. For example, the prospective approach to fraud reduction discussed in Options 9 and 10 could save an additional \$362 billion in medical costs over the next decade. Some aspects of these medical savings were discussed in our first working paper, but most were not.

## **Two caveats**

We recognize that while there are many opportunities to make savings in administrative costs, payers' costs represent a small share of total health spending. The Congressional Budget Office calculates that only 7 cents in every dollar of national health spending goes on "administration and the net cost of private insurance."<sup>1</sup> While administrative costs are certainly worth pursuing, they pale in significance compared with savings opportunities from medical costs.

That points to a second caveat: administrative programs can have important positive impacts on reducing wasteful medical costs. Fraud reduction programs are the most obvious example, where there is ample evidence that Medicare's administrative under-investment in fact costs taxpayers through avoidable fraud.<sup>3</sup> Health plans – and self insured employers - also spend administratively on a wide range of programs that provide patients information to support them make informed choices, and that identify and incentivize best practices on the part of physicians and hospitals.

However many of these approaches are absent from traditional fee-for-service government health programs. By under-investing in modern management techniques, government therefore over-spends on inefficient or wasteful medical services. The Congressional Budget Office estimates that health plans' use of these administrative initiatives can reduce medical

costs by 5-10 percent.<sup>4</sup> It follows that minimizing administrative costs should not be a public policy goal in isolation, and reform options for new programs should be assessed against their ability to tackle the well-documented problems of fraud, waste and inappropriate utilization that affect US health care today.<sup>5</sup>

### **What needs to change**

Our experiences suggest that even where the technology exists and efforts have been made to introduce it, its full potential is not being realized. For example, UnitedHealth Group now has 30 million magnetic swipe cards in circulation that would eliminate much red tape for patients, but full adoption will require greater uptake of matching technology by doctors' offices and hospitals across the nation.

We therefore believe that shared and consistent action is now needed across all payers – commercial and governmental – in partnership with physicians and hospitals, so as to unleash the savings identified in this Working Paper. We call for:

- tighter mandatory data and transaction standards
- the elimination of antiquated manual processes, unnecessary paperwork, and redundant intermediaries
- automated payment accuracy processes across the health care system
- a single credentialing and quality measurement process, and
- a sophisticated and consistent regulatory regime.

In this way we think it should be possible to better balance two objectives: innovation and continuous improvement from choice and competition between America's 1300 payers, while removing the cost of duplicative and inconsistent administrative processes.

In doing so, we believe it is possible to distinguish between value-added administrative programs, versus those that add little and simply exist for historical reasons. Making that distinction is what we set out to do in this Working Paper. The result, we hope, is a substantive contribution to the formulation of a "route map" to better care with less red tape and lower administrative overhead.

### **References**

<sup>1</sup> Congressional Budget Office, December 2008: Key issues in analyzing major health insurance proposals. Page 19, Table 1-4

<sup>2</sup> CBO Op cit. Page 69, Table 3-1

<sup>3</sup> See for example recent reports from the US Government Accountability Office: Medicare: Improvements Needed to Address Improper Payments in Home Health, GAO-09-185 February 27, 2009; Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process, GAO-08-955 July 3, 2008; Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices, GAO-08-452 June 13, 2008

<sup>4</sup> CBO Op cit. Page 67

<sup>5</sup> It is for this reason that the CBO argues that 'medical cost ratios' (which measure the share of spending on medical costs versus administrative items) may not be good indicators of a plan's efficiency or value. CBO Op cit.

# Summary of proposed actions/recommendations

A. Required use of common technology and information standards, with enhanced interoperability and connectivity	2010-2019 Savings
<b>Option 1: Rapidly develop and adopt system-wide data and transaction standards</b> to simplify administration and improve patients' diagnosis, treatment and outcomes.	<b>Foundational</b>
<b>Option 2: Use of automated cards</b> to validate patient eligibility and benefits at the point of service.	<b>~\$18 billion</b>
<b>Option 3: Eliminate explanation of benefits for each transaction</b> and replace with monthly personalized health statements, delivered through secure online portals where possible.	<b>~\$14 billion</b>
<b>Option 4: Eliminate paper checks and Paper Remittance Advice</b> in favor of electronic funds transfer and electronic remittance advice.	<b>~\$109 billion</b>
<b>Option 5: Implement multi-payer transactional capability</b> on Practice Management Information Systems.	<b>~\$29 billion</b>
<b>Option 6: Expand use of Electronic Data Interchange</b> for claims, eligibility and coverage verification, notification/administration and claims status.	<b>~\$31 billion</b>
<b>Option 7: Integrate Practice Management Information Systems and payer administrative systems.</b>	<b>~\$11 billion</b>
<b>Option 8: Integrate essential elements of electronic medical records and personal health records</b> and promote information sharing and use of data to improve prevention and coordination of care.	<b>~\$13 billion</b>
B. Use advanced system-wide techniques to improve payment speed and accuracy	
<b>Option 9: Use predictive modeling to prescore claims</b> for Coordination of Benefits, upcoding, subrogation, fraud and medical management prior to payment.	<b>~\$47 billion</b>
<b>Option 10: Create a national payment accuracy clearinghouse</b> to settle under-payments and over-payments.	<b>~\$41 billion</b>
C. Streamlined provider credentialing, privileging and quality designation processes	
<b>Option 11: Eliminate multiple payer credentialing and separate hospital privileging.</b> Develop industry utility for credentialing.	<b>~\$18 billion</b>
<b>Option 12: Adopt common quality designation standards</b> and create single health information database for quality determination.	<b>~\$1 billion</b>

**Potential administrative savings to the health care system by applying these selected programs are estimated at approximately \$332 billion during 2010-2019, assuming reasonable implementation phasing.**

## Option 1 Rapidly develop and adopt health system-wide data and transaction standards to simplify administration and improve patients' diagnosis, treatment and outcomes.

**Current system:** The nation's health care system badly lags behind many other sectors of the U.S. economy in terms of its use of widely adopted data and transactional standards. The results include: frequent inability to properly coordinate patients' care; doctor and hospital frustration at the amount of administrative red tape; and excessive cost incurred on administrative activity that does not add value to health care. Paper-based processes are all too typical where technology could easily streamline care funding and delivery.

Progress made through HIPAA standards is a first step toward administrative simplification, helping facilitate electronic interactions between payers and care providers. But these standards still leave too much room for variation caused by payer-specific requirements and multiple "companion guides." If health care is to advance to the level of interoperability found in many other industries, there need to be new guidelines that eliminate variation in data and transaction standards, while meaningfully enhancing the value of the data exchanged. These standards should enable direct exchange among participants in the system, as opposed to using translation intermediaries or clearinghouses. Currently, the industry has embraced several standards-setting organizations, with specific recognition given to X12 and CORE as the two best situated to develop administrative exchange guidelines.

**Proposed solution:** We recommend and support much more rapid adoption of tighter data and transaction standards, starting with CORE Phase I and II eligibility and benefit rules, then moving quickly on to tightened standards for exchanging other HIPAA items, including claims submission, claims inquiry, electronic funds transfer, electronic remittance and auto posting, prior authorization/notification, and demographic updates. These new standards should also cover critical encounter data, such as care plan, lab results, conditions and Rx orders. We envision this information being shared with individuals through a Health Information Exchange in a fully secure, private environment. The information will then assist care providers and health plans in engaging patients and coordinating care.

**Estimated cost savings:** Wider and faster adoption of programs using these standardized types of clinical data would over time help reduce lifestyle-driven illnesses, improve patient safety, advance the adoption of "pay-for-performance" programs and support innovative benefit designs that reward people for adopting healthy behaviors. However, data and transaction standards on their own produce few savings, and should instead be regarded as "foundational." Because other sections of this Working Paper (Options 2, 4-8 and 12) require use of these standards to make further advances, the savings are not separately quantified under this option.

## Option 2 Use automated cards to validate patient eligibility and benefits at the point of service.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.4	0.7	1.1	1.1	3.3	9.9
Provider	0.0	0.3	0.6	0.9	1.0	2.8	8.3
<b>Total</b>	<b>0.0</b>	<b>0.7</b>	<b>1.3</b>	<b>2.0</b>	<b>2.1</b>	<b>6.1</b>	<b>18.2</b>

**Current system:** When a patient visits a doctor’s office or hospital, the clerical staff often photocopy information from the patient’s health plan identification card. To verify eligibility, about 60 percent of providers’ offices access a health plan’s call center. This process, and the subsequent claims submission and adjudication are typically performed after care has been provided. These manual methods cause delays in processing that are costly and confusing to patients. They also result in delayed billing and settlement, which can make it harder for physicians to be paid what they are owed by the patient. This contributes to an estimated \$60 billion in bad debt write-offs annually across the health care system.

**Proposed solution:** Using secure swipe card technology – or an appropriate automated link to a doctor’s or hospital’s systems – the provider can view in real-time the patient’s eligibility for benefits, and accurately ascertain what will be reimbursed by the insurer/employer. The doctor or hospital can then request payment for the visit in real time while submitting a claim electronically to the health plan or other payer. UnitedHealth Group currently has 30 million medical ID swipe cards in circulation that can achieve this solution. Besides the efficiency gains in eligibility and benefit verification, these cards also contribute to better care by providing doctors with access to a patient’s personal health record and relevant health alerts. Barriers to higher adoption of this technology include lack of consistent data standards, provider reluctance to alter workflows and practices, and lack of development and use of multi-payer applications in PMIS systems.

To overcome these barriers to adoption we recommend that: 1) all health care payers adopt WEDI identification card standards and electronic eligibility capabilities; 2) payers agree to provide a single access point for eligibility information and electronic claims filing; 3) health care providers be incentivized from the future savings stream to acquire the relevant technology and broadly implement it in their practices; and 4) PMIS systems be extended to include basic multi-payer inquiry and claims submission capability.

**Estimated cost savings:** Incentivizing or mandating electronic eligibility adoption to 95 percent by 2019 results in an estimated \$18.2 billion in savings over 10 years. It should also be noted that other benefits from this option have not been included in the savings estimates. These include the likelihood that for each 10 percent increase in electronic eligibility verification there is a 3 percent increase in total eligibility verifications; eligibility write-offs fall by 2.5 percent as a percent of net patient revenue; and there are other general reductions in administrative burdens in care providers’ offices. These would be likely to offset the investments needed to implement these changes, which in the case of providers would include third track card readers (if they choose swipe technology), the ability to import benefits and payment information into their PMIS system, and related PMIS system upgrades.

### Option 3 Eliminate explanation of benefits (EOBs) for each transaction and replace with monthly personalized health statements, delivered through secure online portals where possible.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.5	0.7	1.2	1.5	3.9	14.4
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>0.0</b>	<b>0.5</b>	<b>0.7</b>	<b>1.2</b>	<b>1.5</b>	<b>3.9</b>	<b>14.4</b>

**Current system:** After a patient visits a health care provider, an explanation of benefits (EOB) is delivered, usually by mail. It describes the services provided, the payment sent to the doctor, and the amount the patient can expect to pay. Stamped on the document are the words, “This is not a bill.” Most payer systems send EOBs for every claim and may be required by law to do so. This can lead to confusion, wasted resources and unpaid bills.

**Proposed solution:** Individual EOBs for each service should be universally replaced with a monthly health statement. The statement would combine all health care activity and explain clearly to patients which elements their employer/insurer was responsible for. Even better, a truly modern health system would have consumers receiving their statements electronically through a secure health plan portal, reducing the number of mailings to members – saving postage, processing, and paper – as well as time spent clarifying the meaning of mailed EOBs by customer service representatives. That is what UnitedHealth Group already does to the extent permitted by state law – and that is the approach that should be universally available across the health care system.

**Estimated cost savings:** Migrating individual paper EOBs to monthly paper statements would save \$9.6 billion over the next 10 years. By moving to online statements, an additional \$4.8 billion would be saved for a total savings of \$14.4 billion. Further savings (which have not been quantified in these estimates) would result from reduced calls among patients, care providers and payers.

## Option 4 Eliminate paper checks and Paper Remittance Advice in favor of electronic funds transfer and electronic remittance advice.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	1.5	1.8	2.2	2.5	8.0	21.7
Provider	0.0	6.1	7.3	8.6	10.0	32.0	86.9
<b>Total</b>	<b>0.0</b>	<b>7.6</b>	<b>9.1</b>	<b>10.8</b>	<b>12.5</b>	<b>40.0</b>	<b>108.6</b>

**Current system:** When health care providers treat patients, they submit claims by manual and electronic means to health plans or other payers for payment. The plans then adjudicate the claims and send payments (usually checks), and remittance advices (printed and mailed) to the providers. Providers then reconcile payments, assess patient responsibility and bill patients. McKinsey estimates that doctors and other health care providers spend \$100 billion or more on the laborious process of managing claims submissions. UnitedHealth Group's OptumHealth 2008 survey of physician practices found that 20 percent of physicians were submitting all claims electronically, 6 percent were receiving all remittance advices electronically and only 3 percent were receiving all payments electronically. Larger numbers of physicians were using a combination of paper-based and electronic systems: 68 percent for submitting claims, 57 percent for receiving remittance advices and 47 percent for receiving payments. When asked what prevented them from fuller adoption of electronic claims processing and payment, those surveyed cited physicians' preference and the lack of a reliable, easy-to-use system that encompassed all payers.

**Proposed solution:** Providers should be required to receive both claims payments and remittance advices electronically, eliminating millions of dollars in printing and postage costs and improving efficiency with bundled payments deposited directly into providers' bank accounts. Providers' administrative staff could then access Electronic Remittance Advice (ERAs) through an online system that lets them view, print and/or download ERAs into their own practice management system. The technology for this solution exists today. UnitedHealth Group's commercial business already delivers 55 percent of claims payments and remittances electronically to more than 400,000 health care professionals nationwide. The largest electronic claims payment systems include Emdeon, Payformance and OptumHealth Electronic Payments and Statements (EPS).

**Estimated cost savings:** Mandating electronic payment adoption so that it increases from 40 percent to 90 percent by 2019 could save the U.S. health care system an estimated \$109 billion over the next 10 years.

## Option 5 Implement multi-payer transactional capability on PMIS systems.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.2	0.3	0.3	0.4	1.2	3.2
Provider	0.6	1.2	2.7	2.8	2.8	10.1	26.2
<b>Total</b>	<b>0.7</b>	<b>1.4</b>	<b>3.0</b>	<b>3.1</b>	<b>3.2</b>	<b>11.3</b>	<b>29.4</b>

**Current system:** Most Practice Management Information Systems already allow the creation of basic claims formats, and many have the ability to post what is known as a “standard 835 transaction.” Some also have the ability to handle so-called 270/271, 276/277 and other standard HIPAA transactions. But most of these systems do not have the ability to handle the multitude of payer specific requirements (“companion guides”). Indeed, some older systems do not have the ability to generate a HIPAA-compliant version of these transactions. These limitations mean that providers often use an intermediary clearinghouse to gain access to all payers. These clearinghouses also provide varying degrees of format translation, HIPAA validation, and claims editing services to help providers with compliance and reimbursement. Since no single clearinghouse provides a full “all payer” connectivity, each clearinghouse “trades” connectivity with other clearinghouses to create a network that enables all payers to be reached. In this piecemeal system, a single claim may traverse three or more “hops” each with its own edits before reaching the payer. In addition to the direct cost associated with this process, a “claims failure” may happen at any point in this chain of custody, with limited visibility as to where denials may have occurred and the rationale for those denials. Likewise, the payer cannot be assured that the information received has not been inappropriately modified in some way by one of the intermediary steps.

**Proposed solution:** If all of the variation arising from individual payers’ requirements were eliminated, direct provider PMIS to payer connectivity would be possible (although some form of intermediary clearinghouse might still be needed for production control, validation, customer services and updating of health plan and provider connectivity). The resulting system would have far fewer clearinghouses and would support a few super-regional hub gateways (potentially as part of the NHIN) that aggregate payer connectivity and that provide gateways to direct provider connectivity or local geographic aggregator exchanges (HIEs). These gateways would handle the full range of electronic connectivity for payers and could, in addition to providing administrative and financial functions, also provide clinical connectivity and analytics. Combining administrative and clinical functions would result in vibrant regional health information exchanges. In order to realize this potential, government should promote this approach by:

- Supporting national standards and specifications for regional gateways
- Setting a timetable for implementation of clinical, administrative, analytics, and financial modules
- Rolling-out and enforcing a single, non-variable format for all administrative transactions
- Providing the national regulatory infrastructure for privacy and security for the whole health care system.

## Option 5 (Cont.)

### Regional Gateway Functions

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- **Clinical transactions**

- Electronic health records
- Labs results
- Pharmacy
- Clinical summary
- Personal health records

- **Administrative transactions**

- Real time adjudication/integrated payer rules
- Claims eligibility, coverage, status

#### **Quality and analytics**

- Integrated clinical and administrative data
- Common provider measurements & processes

#### **Financial transactions**

- Electronic funds transfers
- Statement remittances

**Estimated cost savings:** Implementing a technology gateway by 2012 results in an estimated \$29 billion in savings by 2019. Using data from the California Office of Statewide Health Planning and Development (OSHPD) and the recent Casalino study, we estimate that the total internal administrative costs for provider interactions related to claims transaction and payment is around \$60 billion per year. Full standardization and common exchange pathways would lower the cost of these interactions and associated technology, billing and clearinghouse costs, which total an additional \$9 to \$12 billion a year.

## Option 6 Expand use of Electronic Data Interchange for claims, eligibility and coverage verification, notification/administration and claims status.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.6	2.0	2.7	2.9	8.4	24.9
Provider	0.0	0.2	0.5	0.7	0.7	2.1	6.2
<b>Total</b>	<b>0.1</b>	<b>0.8</b>	<b>2.5</b>	<b>3.4</b>	<b>3.6</b>	<b>10.5</b>	<b>31.1</b>

**Proposed solution:** In addition to the use of smart cards (Option 2) and EFT and ERA (Option 4), providers could also adopt EDI for claims status checking (276/277) and other eligibility verification outside scheduling and registration processes for coverage verification.

**Estimated cost savings:** Advancing the use of EDI on a staged basis through 2012 results in \$31 billion in savings over 10 years.

The savings rates associated with each transaction type vary, however, it is generally accepted that a blended savings rate of \$2.20-\$2.30 accrues to the system for the use of each electronic transaction. This ranges from about \$1 per claim, \$2.50 per eligibility check, more than \$10 for some referrals and \$50 or more for processing a denied, appealed claim. Net of the savings that have already been captured in Options 2 and 4, we estimate that 95 percent adoption for EDI for all eligibility checking and claims status checking would yield an additional savings of \$31 billion over 10 years.

## Option 7 Integrate PMIS and payer administrative systems, minimizing the need for clearinghouses.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.1	0.1	0.1	0.1	0.5	1.3
Provider	0.3	0.5	0.9	1.0	1.0	3.7	9.4
<b>Total</b>	<b>0.3</b>	<b>0.5</b>	<b>1.1</b>	<b>1.1</b>	<b>1.2</b>	<b>4.2</b>	<b>10.7</b>

**Current system:** The majority of practice management information systems currently do not connect directly to payer adjudication systems, as a result of payer-specific variations. Instead, claims are usually transmitted through clearinghouses and other intermediaries and may traverse three or more “hops” prior to reaching their final destination.

**Proposed solution:** If all payer-specific variations were removed from the health care system, direct PMIS-payer connectivity could be achieved through a “pure technology” intermediary that correctly identifies appropriate counterparties for claims transmissions and which is continually updated to reflect new counterparty connections. Alternatively, both providers and payers could adopt ASP-based adjudication and POMIS systems. This solution reflects a stripped down version of Option 8 without the full benefits of the value-add that could exist within “technology gateways.”

**Estimated cost savings:** The savings in this option are over and above those detailed in Option 5. Increasing integration between payer and care provider systems could result in an estimated \$11 billion in savings over 10 years. Savings from reductions in manual transactions are mostly reflected in other sections of this Working Paper. However, the incremental impact of reducing the need for intermediaries is estimated at \$0.75 billion to 1.25 billion annually, based on a \$1.5 billion to \$2 billion market spend on clearinghouses minus the impact of Option 5.

## Option 8 Integrate essential elements of electronic medical records and personal health records and promote information sharing and use of data to improve prevention and coordination of care.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.0	0.3	0.7	1.0	2.0	9.9
Provider	0.0	0.0	0.1	0.2	0.3	0.7	3.3
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.4</b>	<b>0.9</b>	<b>1.4</b>	<b>2.7</b>	<b>13.2</b>
<i>Medical, non additive</i>	<i>0.0</i>	<i>0.0</i>	<i>3.2</i>	<i>6.7</i>	<i>10.5</i>	<i>20.4</i>	<i>101.9</i>

**Current system:** The nation’s health care system currently lacks critical information-sharing between patients, hospitals and doctors, and payers. Too often, even where they have been adopted, Electronic Medical Records (EMRs) do not integrate with Personal Health Records (PHRs). Arguably the most complete longitudinal and usable records of care reside within payer databases – particularly those capable of episode treatment aggregation, integrated PHR display and national population surveillance, like those found at UnitedHealth Group.

**Proposed solution:** To make health care truly interoperable, the capabilities of EMRs need to be integrated with the PHRs. The best source for these PHRs are those that validate the underlying activity through to claims payment, and which therefore reside with the payer. However, these PHRs do not currently contain the critical information to ensure proper follow-up by patients and their various care providers, that can only be supplied by the care provider, including Rx orders, lab values, care plans and referrals, all of which largely go unmonitored. UnitedHealth Group has developed a national system which is updated daily with individual patient data and then prioritizes the patient’s health care needs each night, for outreach by over 12,500 of our clinicians and other support staff, who ensure any missing care is provided in a timely manner. This helps patients keep medications refilled, ensures that tests are administered at proper intervals, wellness routines and education are properly supported and evidence-based medicine guidelines are followed.

These activities form a vital care coordination function that is not universally available across the health care delivery system.

**Estimated cost savings:** If implementation of this solution is phased-in between 2012 and 2014, administrative cost savings over the next decade are estimated at \$13 billion. We expect an additional \$102 billion in medical cost savings would be associated with this solution. Because this option relies in part on the adoption of EMRs, the full benefits of the program would take some time to achieve. However, we regard this as feasible given that UnitedHealth Group, for example, already has the capacity to administer a national surveillance system. It would need little time to fully aggregate all payer data and EMR outputs to achieve the full potential benefits of this option.

## Option 9 Use predictive modeling to pre-score claims for COB, upcoding, subrogation, fraud and medical management prior to payment.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	2.1	4.5	4.8	5.1	16.4	47.4
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>0.0</b>	<b>2.1</b>	<b>4.5</b>	<b>4.8</b>	<b>5.1</b>	<b>16.4</b>	<b>47.4</b>
<b>Medical, non additive</b>							
<i>Commercial</i>	<i>0.0</i>	<i>10.9</i>	<i>23.4</i>	<i>25.0</i>	<i>26.5</i>	<i>85.8</i>	<i>248.4</i>
<i>Government</i>	<i>0.0</i>	<i>6.2</i>	<i>10.0</i>	<i>10.8</i>	<i>11.6</i>	<i>38.6</i>	<i>113.3</i>

**Current system:** The FBI’s financial crimes report in 2007 estimated that somewhere between 3 percent to 10 percent of total health care spend is attributable to fraud, overpayments, coordination of benefits and subrogation errors. This means that up to \$260 billion a year in associated costs are due to health care fraud. According to the National Health Care Anti-Fraud Association, approximately 70 percent of payers currently employ some form of anti-fraud system mostly following a “pay and chase” methodology – that is, they attempt to correct the problem after it has occurred.

**Proposed solution:** A national predictive model pre-scoring service would actively monitor and flag claims prior to payment, leading to a more robust real time adjudication process for most payments. This service, coupled with the establishment of a national payment accuracy clearinghouse (Option 10), would reduce the instances of mispayment and administrative friction between payers and providers.

**Estimated cost savings:** UnitedHealth Group’s experience suggests that savings are obtainable of between 2 percent and 7 percent (depending on the type of health service) for employer-sponsored and the Medicare and Medicaid programs, net of associated contingency and recovery costs. Applying these figures nationally, we estimate that implementing payment accuracy-related predictive modeling, in combination with the Payment Accuracy clearinghouse (discussed as Option 10), has the potential to reduce administrative costs associated with inappropriate medical payments over the next decade by \$47 billion. In addition, as the health care system becomes better at detecting fraud, waste and abuse, the incidence of fraud is likely to decline.

We also anticipate that medical costs related to overpayments could be reduced by an estimated \$362 billion over the same period.

## Option 10 Create a national payment accuracy clearinghouse to settle under-payments and over-payments.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	1.0	2.1	2.2	2.2	7.5	20.3
Provider	0.0	1.0	2.1	2.2	2.3	7.6	20.4
<b>Total</b>	<b>0.0</b>	<b>2.0</b>	<b>4.2</b>	<b>4.4</b>	<b>4.5</b>	<b>15.1</b>	<b>40.7</b>

**Current system:** Processing over/under payments is a costly and time consuming process marked by a high degree of manual intervention and investigation, but with varying degrees of effectiveness.

**Proposed solution:** Deploy a national, third party clearinghouse to audit and ensure correct payments. If combined with adoption of a single, non-variable format for all transactions, the added transparency would make contract compliance much easier for both providers and payers. This would mean payers and providers shared a common platform to address payment errors and settle credit balances, allowing for inventory management, electronic settlement and reporting and audit. This shared utility would still permit appropriate analysis of payment data and data mining – either by the clearinghouse itself or the individual payers.

**Estimated cost savings:** Implementation of a national payment accuracy clearinghouse could result in \$41 billion in savings over 10 years. We estimate that a 20 percent to 30 percent reduction in spending by hospitals, physicians and payers on collections and claims management can be achieved through such a national payment accuracy clearinghouse, as a result of centralized credit resolution, reductions in the number of payer-provider interactions needed to resolve a claim, and pre-and post-tracking of outstanding credit resolution balances. This equates to potential savings on the provider side of \$1.5 billion to \$2 billion of administrative cost, and for payers, savings of \$2 billion to \$3 billion. (Note: the estimated value of reducing mis-payments has already been captured in Option 9.)

## Option 11 Eliminate multiple payer credentialing and separate hospital privileging. Develop industry utility for credentialing.

	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.0	0.6	0.6	0.7	0.7	2.6	7.1
Provider	0.0	1.0	1.1	1.1	1.1	4.3	10.5
<b>Total</b>	<b>0.0</b>	<b>1.6</b>	<b>1.7</b>	<b>1.8</b>	<b>1.8</b>	<b>6.9</b>	<b>17.6</b>

**Current system:** Health plans typically have their own unique credentialing requirements for participating physicians and hospitals. Providers often need to apply for accreditation from each insurer separately. For hospitals, this process can cost up to \$60,000 per application. In addition, physicians are subjected to various hospital privileging processes using varied criteria.

**Proposed solution:** Using a single standardized process for accreditation and licensing nationwide would reduce costs for physicians and hospitals without compromising quality. The government could facilitate this process by creating an antitrust safe harbor allowing hospitals and health plans to agree on common rules and standards. An industry program would then be developed and deployed for provider credentialing.

**Estimated cost savings:** Implementing a single credentialing and hospital privileging process used by all payers could result in \$18 billion in savings over 10 years. As part of that overall estimate, we estimate that standardizing credentialing and licensure requirements could reduce care provider administrative costs by about a billion dollars per year with savings of \$10.5 billion over 10 years.

## Option 12 Adopt common quality designation standards and create single health information database for quality determination.

(Billions of Dollars)	2010	2011	2012	2013	2014	2010-2014	2010-2019
Payer	0.1	0.1	0.1	0.1	0.1	0.5	1.1
Provider	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.1</b>	<b>0.5</b>	<b>1.1</b>

**Current system:** While progress has been made in standardizing physician performance measurement, significant variability in this activity remains across the health care system. Physicians are often measured by multiple parties using different measures and methodologies. In addition, the underlying data necessary for performing measurement is suboptimally coordinated across providers, facilities, and health plans, which often presents challenges for the data aggregation necessary for statistically significant analyses. The end result is suboptimal quality of care, which results in inefficient and wasteful use of health care assets.

**Proposed solution:** Accelerate the adoption of industry-wide rules and systems for data aggregation and measurement methodologies. Health plans and Medicare, working collaboratively with physicians, hospitals and other key stakeholders, would agree on the infrastructures and processes necessary to efficiently pool local data across health plans and settings of care. A new independent public/private partnership at the national level would lead and accelerate consistency in the processes necessary to achieve this and ensure uniformity across the country. As a result, physicians would be able to access, correct and utilize their local aggregated data for performance improvement. Researchers and others would have benefit of aggregated data for the purposes of tracking and developing quality improvement interventions.

Regarding performance measures themselves, and the methodologies underlying the process of performance measurement, there currently exists a useful infrastructure upon which to build. The recent infusion of federal dollars into the National Quality Forum provides the essential oversight and endorsement of proposed measures' scientific accuracy based upon best available evidence. The AMA's Performance Consortium for Performance Improvement provides a forum for expert physicians, and their specialty societies, to develop and test specialty-specific measures, but requires augmented financial support. Finally, specialty societies themselves require augmented support to accelerate closing the essential link in the translation of science into specific clinical guidance that serves as the foundation for performance measure development. Special attention needs to be devoted to advancing "episodes of care" and other analytic techniques for cost and utilization measurement.

## **Some abbreviations used in this report**

**ASP** – Average Sales Price.

**COB** – Coordination of Benefits.

**CORE** – Committee on Operating Rules for Information Exchange. The Council for Affordable Quality Healthcare (CAQH) launched CORE with the vision of giving providers access to eligibility and benefits information before or at the time of service, using the electronic system of their choice, for any patient or health plan.

**EDI** – Electronic Data Interchange refers to the structured transmission of data between organizations by electronic means.

**EOP** – Explanation of Payment.

**ERA** – Electronic Remittance Advice is the electronic equivalent of the Explanation of Payment. An ERA provides details on how claims were paid and/or why they were denied.

**HIE** – Health Information Exchange.

**HIPPA** – The Health Insurance Portability and Accountability Act. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, require the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers to help people keep their information private.

**NHIN** – Nationwide Health Information Network.

**PHI** – Personal Health Information.

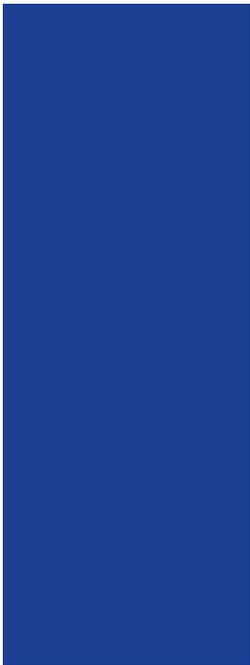
**PMIS** – Practice Management Information System.

**POMIS** – Physicians Office Management and Medical Information Systems.

**PRA** – Paper Remittance Advice. Same as Explanation of Payment (EOP).

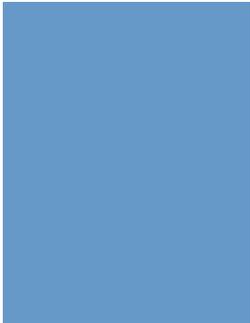
**WEDI** – Workgroup for Electronic Data Interchange.

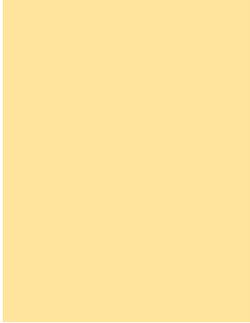
**X12** – The Accredited Standards Committee (ASC) X12 develops electronic data interchange (EDI) standards and related documents for national and global markets.



## **About the UnitedHealth Center for Health Reform & Modernization**

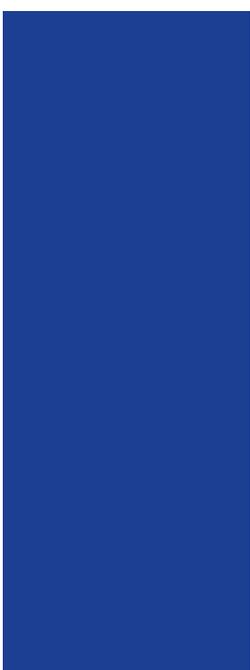
UnitedHealth's new Center serves as a focal point for work on health care modernization and national health reform. The Center assesses and develops innovative policies and practical solutions for the health care challenges facing the nation. Drawing on UnitedHealth Group's internal expertise and extensive external partnerships, our initial work program falls into six priority areas:

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1. Practical cost containment strategies to slow the growth of U.S. health care costs
  2. Payment reform strategies that better support physicians, hospitals and other providers in delivering high quality patient-centered care
  3. Reducing health disparities, particularly in underserved communities
  4. Innovative approaches to universal coverage and health benefits, grounded in evidence-based care and consumer engagement
  5. Modernizing the care delivery system, including strengthening primary care
  6. Modernizing Medicare, including chronic disease management and end-of-life care



For more information, see [www.unitedhealthgroup.com/reform](http://www.unitedhealthgroup.com/reform)

## **About UnitedHealth Group**



UnitedHealth Group serves 70 million Americans, funding and arranging health care on behalf of individuals, employers and government, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals across the nation. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving one in five seniors nationwide – and the largest Medicaid health plan, supporting underserved communities in 22 states and the District of Columbia.

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