

## Administrative Simplification for Payers and Providers

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Welcome everyone. Thank you for having us present to you today the financial services and healthcare convergence we are seeing in the marketplace due to healthcare reform. That will be our topic for today. We're going to cover this topic a few different ways, but particularly with a financial services lens. This topic is going to be something that covers our healthcare provider and our healthcare insurance clients, as well as service providers and administrators who service the healthcare industry.

Let's take a quick poll and find out how many healthcare providers and healthcare payers are participating in our discussion today. There's a question on your screen, and we'd love to see who is participating with us today. Okay, the numbers are changing a little bit. Some people decided they want to play for the other team. That's great. So for now it looks like we've got a good representation: 70 percent of our participants are from healthcare providers and 29 percent from the health plan industry. And this topic absolutely affects the entire industry.

Let's begin with an environmental scan of what's happening in the industry and the situation in terms of efficiency in the way health care gets delivered today. This is, I'm sure, a subject you are all quite familiar with.

We're going to highlight things that have already occurred in terms of implementation that is affecting health care delivery in the United States – and that is the impact of the American Recovery and Reinvestment Act of 2010 and, specifically, the HITECH section of that act. We're also going to take a look at a part of the legislation that is going to continue the further goal of administrative simplification, and we'll spend quite a bit of time on that and on the operating rules and the standards that are going to be mandated because of that. These new mandates are already having an impact on the healthcare industry, of course, and have been implemented over a period of time through other types of legislation, and they'll continue to do so in the near-term.

Moving on to the current effects of how health care is impacted related to the stimulus package, we're turning now to our page related to HITECH-specific responsibilities. HITECH has created new reasons for financial institutions to pay attention to how they handle healthcare transactions.

What we wanted to bring to your attention today are three specific areas around HITECH-specific responsibilities that banks are having to pay attention to related to their payments business. Security-related requirements are new for many banks. Many banks are already offering lockboxes and other types of payment services to their clients, and they are handling protected health information potentially related to their receivables and their payables business. The new changes that banks, starting in February of 2010, have had to consider are do they have the appropriate security and oversight, governance within their firm to handle the formal requirements of protected health information. The contract aspect of this has always in place through the process of a business associate arrangement. The requirements of HITECH will now require banks to more formally report out its privacy and breach activities related to protected health information. So this is a new requirement on the part of banks.

In addition, new regulatory oversight is now required of banks on these breach reporting activities. There must be an annual report that banks submit to Health and Human Services, and this is not something that banks have been familiar

with in the past. We absolutely have had a commitment and a responsibility to our client base to ensure that we report breaches as a business associate, but the heightened security requirements around reporting to Health and Human Services is something that is new for banks.

The last item that I would highlight here is risk-management oversight requirements that HITECH now imparts upon the banking industry. Not only do we need to report on an annual basis in terms of our breach activity, but there are threshold breaches that will require additional reporting and notification on the part of banks. This reporting is something that will need to have implied enhanced governance across the banks' compliance organizations to ensure that there is a process and a reporting mechanism that can take care of meeting the proper breach requirements. And specifically, at the bottom of the page around new risk-management requirements that I've listed, I'll give you an example where the regulation states that any breach over 500 records now has to be immediately notified to the Department of Health and Human Services; these will then be published on its website.

We've actually seen cases in this new environment where state attorneys general are taking advantage of new enforcement powers that they have when protected health information breaches occur. This is something that will also affect the banking community as it continues to handle protected health information. New powers will also be available to state attorneys general on behalf of individuals in the instance of privacy breaches.

So I know that's a bit technical, and I know that it's potentially an area that's new in terms of how you interact with your banking partners. I'd be interested to ask if any of you on the line today have discussed HITECH with your banking partners, or if this is a subject that's new for you?

Fantastic. We see that this is something that is emerging still in your conversations with your banking partners. I would gather that, in some cases, we are seeing a renewed interest on the part of our clients as we continue to have to deal with the effects of implementing healthcare reform. I would say that this will continue to be part of the conversations that we will have with customers. I'd say also, in addition, banks are also thinking about the best way to be able to have a scaled and routine approach to how we handle protected health information. As data and payments continue to be important to our clients as a manner of handling financial settlement in the healthcare industry, we're going to continue to be dealing with these issues.

Now let's turn our attention to the impact of the legislation that got passed in March. What are the effects of the new law? Let's first talk about overall the impact to insurance coverage. That was the purpose of reform in the first place, and this page gives you an opportunity to size the areas of impact and when the impact will occur and think about it as it relates to the impact of your own organization. Approximately 32 million new consumers are slated to enter the U.S. health care system. That's about 10 percent of the U.S. population. However, many people don't realize that there is a large number that will enter into the system in the next four years. We will see Medicaid population increase by 17 million in the 2014 timeframe.

In addition, over the next five years after that, by 2020, we're going to see an addition 14 million more individuals enter into the health care system due to reform. The channels by which we expect our clients and customers to deal with this will be extremely complex. There's significant government participation as both a regulator and as an overseer of the new state health insurance exchanges and also the guidance that is coming out due to reform around the types of products that are put on the exchanges. Very, very challenging waters to navigate on the part of health plans, additionally challenging on the part of our healthcare service providers and for healthcare hospital clients – because we're going to all be dealing with so many new patients.

As a banking institution, J.P. Morgan is very keen to understand the impact to your clients, because we want to ensure that we're thinking about solutions and ways to help you process administrative activity to support the settlement of these types of clients who are getting new coverage through the healthcare system.

Let's talk a little bit about legislation that is also going to impact these administrative and settlement processes that we've just described, that are going to be related to creating more volume into the health care system, and how the current administrative environment is going to be impacted in other sections of the healthcare bill. The legislation calls for additional standards and enhanced operating rules, and the purpose of these new standards and operating rules is to help cut down administrative costs in the healthcare system. I think there is probably familiarity on this phone of the HIPAA legislation and the Medicare Modernization Act -- two bills that helped start to drive electronic of administrative transactions. The healthcare legislation that was passed in March is a continuation of that work, and the points that are on the page for you today give you some of the goals in the spirit of the new legislation that's been written. It builds on the existing regulations I just described. The real goal is to ensure that operating rules that are going to get written off of the new legislation drive toward simplification of payments and remittance processes.

Clearly the ability to achieve operational standards is going to allow all market participants to help drive straight-through processing. One of the key points about the way the legislation was written is that the point-of-origin of transaction was a big focus of the administrative simplification mandates within the healthcare reform legislation. You will see over the next couple of pages, how the onus will be on the health plans to implement those changes.

Let's take a step back and look at the current state of the payments and remittance flows through the health care system. If we know that there's going to be additional changes to the administrative transactions, which will then potentially change the operating model or the way that transactions are handled in the industry, it's important to reflect upon our current environment. Clearly, one of the reasons for a desire for change, and what was written into the reform bill, is to try to simplify the process that you see on the page that's presented to you. This page shows all the participants and all of the necessary components that are relevant and important to make the healthcare supply chain really occur -- starting with the patient walking in the front door, having treatment, understanding what they owe, understanding what they owe after treatment, and ensuring that the hospital is fairly compensated and the health plan has enough information to adjudicate a claim.

In order to accomplish all of that, you can simply look at this page and say there are a lot of points of activity involved, a lot of variance, and a lot of technology, and a lot of "solutioning" that's thrown at the problem of so many points of interaction in the health care system.

Then take a moment to think about where the bill hopes to drive change for a more cost-efficient system, and I'll throw a couple numbers out to you. Through reform, and we'll talk about how the administrative transactions in reform are going to change, the government is staring at a budgeting save of \$11.6 billion over 10 years. They hope to achieve through a \$7.3 billion save in federal Medicaid spending and an additional \$4.3 billion reduction in the subsidies and the funding that will be applied to state insurance exchanges, through the goal of having the health plans be able to offer more cost-efficient products, and, therefore, a more cost-efficient premium or a more economically priced premium to the marketplace.

Reform is going to require us to think about how we're going to embrace many other components of administrative activity and how the system is going to support administrative activity over and above just the way that we handle settlement in the healthcare system today. Changes in Medicare reimbursement are going to add more complexity into that administrative process. On this page, I've given you a couple of examples. Bundle payments may change the way that billing and settlement will need to occur between health plans and hospitals, and then the delivery of an "accountable" care organization, where many organizations will have to knit themselves together in order to deliver care. These are all streamlined ways for the health care systems to deliver service or care to an individual. But how are we going to go about embracing this, and how will we change the way we deliver our administrative processes today?

The mandate for health plans to reduce cost is going to be one of the areas that will continue to have some pressure, because in the current system, it is not a very scalable system. It's not a very scalable approach to taking on different types of care models and taking on different delivery models. This is a current snapshot of the administrative cost trajectory in the private health insurance market, the Medicaid market, and the Medicare market. You can see that administrative expense, which is typically just overhead and business management expenses, is a very large component of the cost of health care in the U.S. The same is also true on the provider side in terms of challenges related to taking on additional volume -- 17 million new individuals into the health care system. Some of the statistics that we've looked at have told us that approximately 20 percent of the revenue that hospitals get in the front door is spent on having to support administrative processes in their institutions. Billing and insurance-related expenses as a portion of that administrative cost account for 42 percent of cost within the administrative section of a hospital's balance sheet.

Clearly these are very large numbers and hard to drive for efficiencies if you don't have a scalable system. One additional comment that I would make is that this is also borne out in the bottom-line impact of the way hospitals operate today, where for not-for-profit hospitals we see over 30 percent of the hospital market dealing with a negative operating margin.

Another impact that's important to consider before we talk about where administrative simplification and changes in reform will take us is the trajectory of cost at the payer's bottom line. Cost represents 50 percent of revenue and is expected to rise. We've even seen numbers today across all of the for-profit health plans that represent 60 percent of costs are still a trajectory they cannot contain. There is a new mandate that reform will require health plans to drive additional efficiencies out of this number due to the need to have an 85 percent minimum cost ratio related to medical expenses versus administrative expenses.

This is going to be a challenge for the industry. New mandated standards and operating rules for administrative simplification are one piece of the roadmap that will allow for scalable processes to occur in the industry. It will affect all market participants. It is going to affect both revenue and patient account processes, due to the fact that administrative transactions cover both the claim submission status and reimbursement processes. Due to the mandates within healthcare reform, simplification is going to be a mandate only from the standpoint of just the relative importance of being able to drive for straight-through processing and a reduction in administrative expense, either due to a new cost threshold on the health plan side, or the desire to have a more scalable approach to higher volume coming in the front door of the hospitals.

Very specifically, we talked before about the need and the drive for a more cost-efficient health care system. The Congressional Budget Office has taken the Administrative and Simplification Act and placed it in several buckets. The overall ten-year save is \$11.6 billion dollars. That's a big number, and a number that is something that we'll focus on over the milestones and deadlines related to administrative simplification.

There are five bullets on administrative simplification, and we want to highlight these for you in terms of exactly what they are. We'll talk about them over the next few slides.

The operating rules are going to require a more automated reconciliation and electronic payment process. They must drive for reconciliation and the ability to handle electronic payment and remittance advices together.

There is a new standard for EFT that must be adopted by 2012 and is effective January 1st of 2014. A highlight here is prior to passage of the healthcare reform bill, the EFT transaction was not a HIPAA-covered transaction. That's a significant landmark event. If you think about the current environment for banks now needing to comply with HITECH, banks will now need to think about how the electronic funds transfer payment as a HIPAA transaction will be something that the banking industry can support.

Operating rules for EFT must also be written. The Health Care Pay and Remittance Advice -- commonly known as the 835 rule -- must be adopted by July 2012 and effective on January of 2014. The last point here is that health plans must certify that they can handle the new operating rules, which will allow for automated reconciliation, a standard EFT process and a standard transaction, new operating rules implemented and certified by the end of 2013. In 2014 penalties will start to be incurred by health plans of a dollar per covered life per day until they're compliant.

These are significant dates. They are clearly significant deliverables, and if you think about the goal of the components that we've just described in terms of driving towards simplification, clearly some things will need to change.

Let's stop and take a poll and just reflect on some of the things that we've talked about related to changes in administrative simplification in your organization. I'd be curious for an initial reaction as to whether your organization has discussed these changes, and whether you think your organization is prepared for them. So we'll take a look at that.

Well, I see that it's almost 50/50. We're going up a little bit in terms of maybe not. Okay, so clearly one of the things that is known, is that not everything is known, in terms of how the rules will impact your organizations, or the exact roadmap for what those rules are going to look like. It's a very much expected reaction that we're not going to have every institution prepared for these changes. We are all on a journey together, and this is an excellent reason why we want to have an interchange and a discussion with you all.

Moving on, we're going to talk a little bit now about early impact and observations about the area of administrative simplification, and how this particular set of changes will be reflected in your current environments and in your own shops. These are some early observations about how the industry is handling this area of transaction activity. It will give us an indication of what the trajectory of improvement may be as reform is implemented.

On this slide are some statistics to consider on the complexities in the revenue cycle of our clients. The hospital system is made up of quite a number of institutions serving an incredible amount of patients. The current paper-based and manual processes make it very, very challenging and difficult to reconcile and handle data and dollars. This is an area we know is complex and challenging and one that needs to be addressed.

Conversely, on the payer side, there is a need for a less complex way for information to be passed between health plans and the hospital system. Payments are done in a three-way process. Data travels through a channel that is separate from the payment. The information that is submitted to a health plan may even come through another channel. And then we also have the reimbursement participation from the federal government program, which is treated a different way. Then you have the consumer patient obligation, which may or may not occur through a paper

payment or a card payment. All these complexities require a hospital to deal with multiple inputs to try and handle their financial position and their billing processes.

There are also other components that are away from the financial services industry that also play into this solution and into this process. Data intermediary and information service providers provide not necessarily the same role and are not necessarily in the same plug-and-play area of health care as a health plan or a hospital.

So multiple variations of how the settlement of a health care transaction occurs. Therefore, this legislation is going to impart change and is related to those processes we just described.

This is the beginning of a conversation. This is certainly a set of very complex issues, a set of activities that are embedded in each of your organizations as it relates to legacy processes, platforms and operations. There are certainly goals that everyone is going to drive for as it relates to taking on reform, whether it's driving for process efficiencies, ensuring that there's scalability, ensuring that there's improved accountability related to showing quality of care from a health care provider side, or efficiency and return on investment of medical management products. All these things enter into potential ways forward for payers — and providers, for that matter — as it relates to how to embrace reform and how to handle it on an ongoing fashion. I would venture that payment systems involved in an integrated fashion could help drive many of these goals.

Let's look at how the framework of implementing reform will converge or potentially converge on each of us, as health care implementation now starts to take hold. The National Committee for Vital Health Statistics will be responsible for selecting a nonprofit entity to help develop administrative simplification, operating rules, and new standards that we described in our earlier pages. They will need to:

- Create a standard for the EFT transaction by 2012.
- Adopt new operating rules for the EFT and claims submission transactions by 2012.
- Create an oversight and an implementation of operating rules by January of 2014.

These deliverables are going to need to be handled in a collaborative way. The number of participants, impacts and groups that will need to converge on the deliverables have been listed in the pyramid in front of you.

From a regulatory standpoint, clearly we are foundationally looking at the regulatory body that will be overseeing the implementation, and that is, of course, Health and Human Services. For banks, the Office of the Controller will have an interest in how banks will handle EFT and how banks are complying with HITECH security and breach guidelines. There is going to be a need for expertise and dedicated work on creating these new standards. Many organizations have either been involved in health care or have been involved in privacy and information protection initiative across the banking industry. Everyone has a role to play.

Operating rules are, by contrast, quite different than setting standards. Operating rules allow for governance and oversight; the policing of standards; the way standards are actually implemented; and ensuring that there's a ubiquity in terms of the way that transactions are handled. I would propose to you that systems and the types of infrastructures that could handle the transactions across the rails of the banking industry and the health care industry need to be prepared for the new rules. And they need to be prepared and participate in helping to set standards.

I've described some of the organizations that have been involved historically in setting rules -- both for the banking the industry and for the health care industry. I'd be interested to ask you if you're familiar with these organizations, if you are expecting or have confidence that these organizations will be able to take the reform bill and go through an implementation process and have something that's going to be effective on the backend. I would be interested in people's votes on that.

It looks like we have some folks saying we might need to refresh some of the constituents that might be able to handle some of this work and make sure that there's more understanding and more participation, across all stakeholders as organizations start to converge on rule-setting. I would encourage each of you to reach out to the organizations that you're involved in related to implementation of HIPAA activity to ensure your voice is heard as you start to gather information and educate your own organization.

Now let's turn our attention to the actual timeline and rollout of administrative simplification. As you can imagine and as we've discussed so far, it's critical that information is available, and, as the timeline unfolds, you make yourself aware of what is going to happen. Reform is already in progress, and there are substantial changes that are going to be coming this year and into 2011 and 2012.

The major step that already occurred this year is the HITECH privacy and security guidelines that I mentioned at the beginning of our discussion:

- **In February (for banks).** Reporting, oversight, and awareness that we have new regulators, and we have new potential areas of responsibility as they relate to the state attorneys general are very important for banks to take note of.
- **In March of this year.** When the healthcare bill was signed, healthcare EFT was added into the HIPAA transaction code set. If any of you enjoy a little light reading, you could certainly look at the Social Security Act, and there in section 1173, you would see that electronic funds transfer is now the tenth HIPAA transaction code. So we can give a little birthday candle. It is now effective, but that's not to say that rules and standards are written yet. That's the work that needs to be done, and clearly a very important watch item.
- **In July 2011.** This is the effective date for the creation of the operating rules for eligibility for health plans, eligibility transactions and the health claim transactions. Those are the first deliverables, if you will, that will need to come from the new not-for-profit entity that will be appointed by the Committee for Vital Health Statistics. That's their first deliverable, so that's something that you'll need to keep on your radar screen. These rules will also need to include a way to use a machine-readable identification card, which is also something new to the National Vital Health Statistics. They will have to appoint someone to do that. Additionally, as the health provider and hospital industry have national provider identifier codes, the health plan industry will also have to have a health plan identification code.
- **In 2012.** As we look out yet another year, the effective date — and many of you are already very well aware of this — all covered entities must be fully 5010 compliant by the end of 2012. With that, additionally, health care reform adds into that 5010 activity an operating rule for EFTs and Health Care Payment and Remittance Advice transactions. The health plan identifier must be implemented and effective by October 2012.

That's just a snapshot of what is coming up in the short-term as it relates to administrative simplification, areas our institution is watching very closely as we support many of these transactions on your behalf.

How would you need to prepare? Clearly, getting engaged with a financial service provider and your industry organizations that are supporting some of the impact of new standards and new operating rules are very, very important. These are mandatory changes and the way you can support your organization by understanding the standards and the operating rules will be key.

We do plan on having an ongoing series of activity around the topic of healthcare reform. We plan on keeping you updated as we learn more and as the standards and operating rules workgroups are implemented. We hope you found the update that we've given you today helpful. We'd encourage you to attend the next webinar.