

The Future of Health Care, Which is Kind of a Big Topic

INFORUM, December 11, 2014

Jeff Lemieux

CAQH Overview

CAQH, a non-profit alliance, is the leader in creating shared initiatives to streamline the business of healthcare. Through collaboration and innovation, CAQH accelerates the transformation of business processes, delivering value to providers, patients and health plans.

CAQH helps organizations:

- Streamline coordination of benefits processes with **COB Smart**.
- Ease provider data collection, maintenance and distribution with the **Universal Provider Datasource**.
- Simplify electronic payments and electronic remittance advice enrollments with **EnrollHub**.
- Develop and implement federally mandated operating rules with **CAQH CORE**.
- Track the adoption of electronic administrative transactions with the **CAQH Index**.

Visit www.caqh.org. Follow us on  and 

What is the CAQH Index? Tracks Switch from Manual to Electronic Payer-Provider Business Transactions

Prior Authorization (Medical/Surgical)

Telephone	6,151,851	28%
Fax	2,079,456	9%
Interactive Voice Response (IVR)	3,211,913	14%
Portal / Website	9,928,654	43%
HIPAA 278	1,602,135	7%
Total Authorization Requests	22,974,009	100%

Claim Status Inquiries

Telephone	32,665,776	9%
Fax	2,768,390	1%
Interactive Voice Response (IVR)	24,267,456	7%
Portal / Website	110,500,730	30%
HIPAA 276	196,844,703	54%
Total Inquiries	367,047,055	100%

Percent of all Prior Authorization Requests Conducted Fully Electronically

Aggregate	7%
High	61%
Low	0%
Median	2%

Percent of all Claim Status Inquiries Conducted Fully Electronically

Aggregate	54%
High	97%
Low	0%
Median	53%

Table 9. (draft)

Table 9. DRAFT Electronic Transaction Adoption Rates, Comparable Health Plans, 2012 and 2013
(percent of transactions)

	Fully Electronic (Standardized)		Fully Manual (Phone, Fax)		Partially Electronic (Web Portal, IVR)	
	2012	2013	2012	2013	2012	2013
Claim Submission	90%	92%	10%	8%	NA	NA
Eligibility and Benefit Verification	63%	64%	4%	4%	34%	32%
Prior Authorization	*	7%	*	36%	*	57%
Claim Status	48%	50%	9%	8%	43%	43%
Claim Payment	50%	57%	50%	43%	NA	NA
Remittance Advice**	43%	46%	50%	42%	8%	12%

Source: CAQH Index. All responding health plans.

Note: NA = not applicable.

*Incorporated into the main CAQH Index data collection process for 2013 data, breakdown for 2012 not available.

**2012 RA adoption percentage was revised slightly for consistency with the 2013 figures.

Table 17. (draft)

Table 17. DRAFT 2013 Estimated Transaction Costs & Savings Opportunities, Health Plans, Healthcare Providers, and Industry

		Heath Plan Cost	Healthcare Provider Cost	Industry Cost	Health Plan Savings Opportunity	Healthcare Provider Savings Opportunity	Industry Savings Opportunity
Claim Submission	Manual	\$0.66	\$2.38	\$3.04	\$0.57	\$2.23	\$2.80
	Electronic	\$0.10	\$0.15	\$0.25			
Eligibility and Benefit Verification	Manual	\$2.52	\$3.53	\$6.05	\$2.49	\$3.07	\$5.56
	Electronic	\$0.03	\$0.46	\$0.49			
Prior Authorization	Manual	\$3.98	\$13.67	\$17.65	\$3.95	\$8.93	\$12.88
	Electronic	\$0.04	\$5.14	\$5.18			
Claim Status Inquiries	Manual	\$4.85	\$2.86	\$7.71	\$4.81	\$1.23	\$6.04
	Electronic	\$0.03	\$1.63	\$1.66			
Claim Payment	Manual	\$0.18	\$4.15	\$4.33	\$0.14	\$3.04	\$3.18
	Electronic	\$0.05	\$1.10	\$1.15			
Remittance Advice	Manual	\$0.17	\$5.36	\$5.53	\$0.13	\$4.17	\$4.30
	Electronic	\$0.04	\$1.18	\$1.22			
Claim Attachments	Manual	\$0.63*	\$5.43*	\$6.06			
	Electronic	NA	NA	NA			
Prior Authorization Attachments	Manual	\$0.45*	\$44.20*	\$45.94*			
	Electronic	NA	NA	NA			

Sources: CAQH Index, Milliman Inc.

Note: NA = not available.

*Very Preliminary – reflects a limited number of respondents with data.

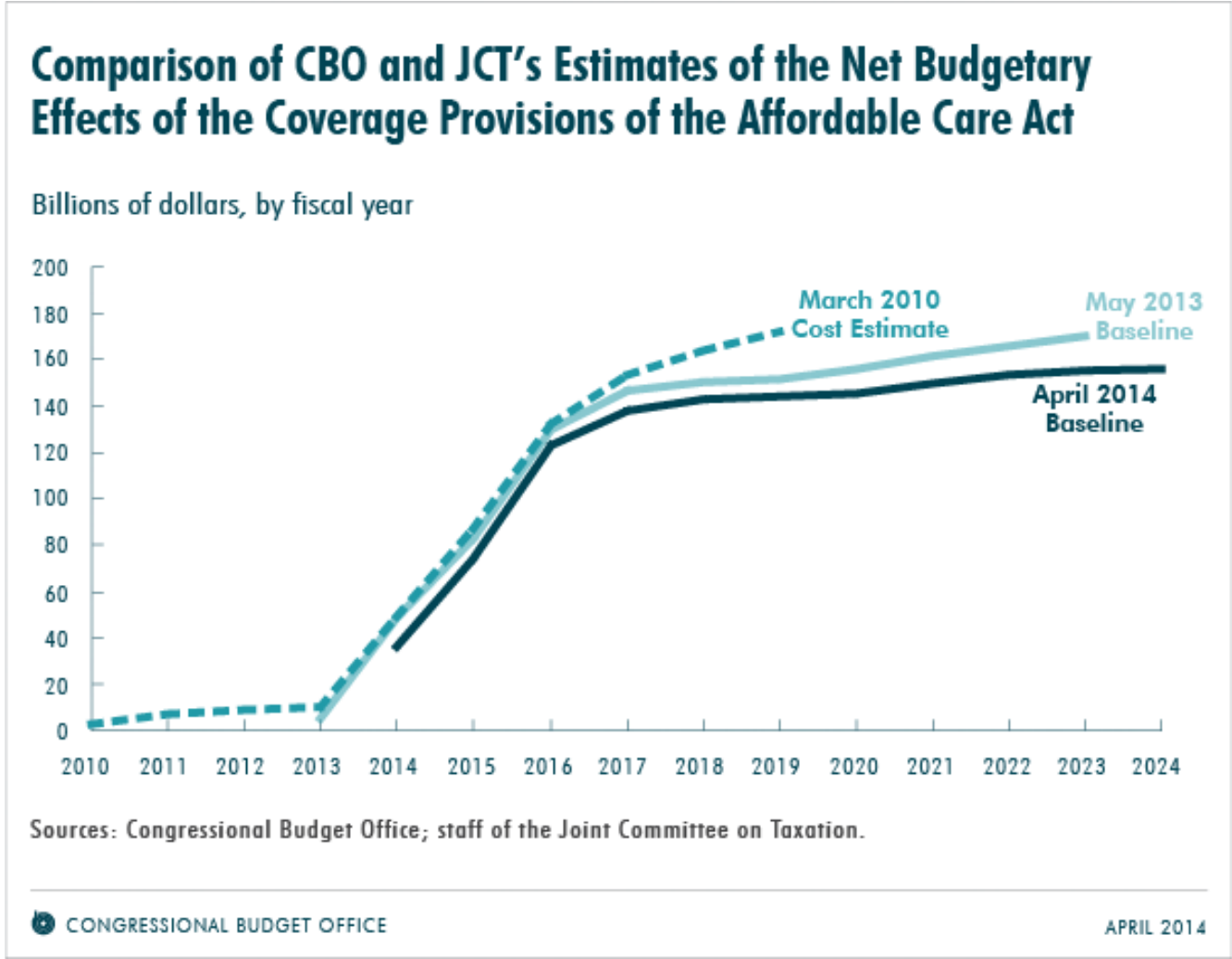
CBO FY 2014 Final Medicare Spending Still Slow

Major Category	Total Outlays (Billions of dollars)			Percentage Change, 2013 to 2014	
	2012	2013	2014	Actual	Adjusted
	Defense—Military	651	608	578	-4.9
Social Security Benefits	762	803	840	4.6	4.6
Medicare	469	495	509	2.8	2.8
Medicaid	251	264	301	13.6	13.6
Unemployment Benefits	96	72	48	-33.2	-33.2
Other Activities	<u>1,026</u>	<u>1,057</u>	<u>1,034</u>	-2.2	-1.9
Subtotal	3,255	3,300	3,311	0.3	0.4
Net Interest on the Public Debt	258	259	271	4.8	4.8
Troubled Asset Relief Program	24	-9	-4	n.m.	n.m.
Net Payments to GSEs	<u>0</u>	<u>-97</u>	<u>-74</u>	n.m.	n.m.
Total	3,537	3,454	3,504	1.4	1.6
Percentage of GDP	22.2	20.8	20.3	n.a.	n.a.

Sources: Congressional Budget Office; Office of Management and Budget; Department of the Treasury.

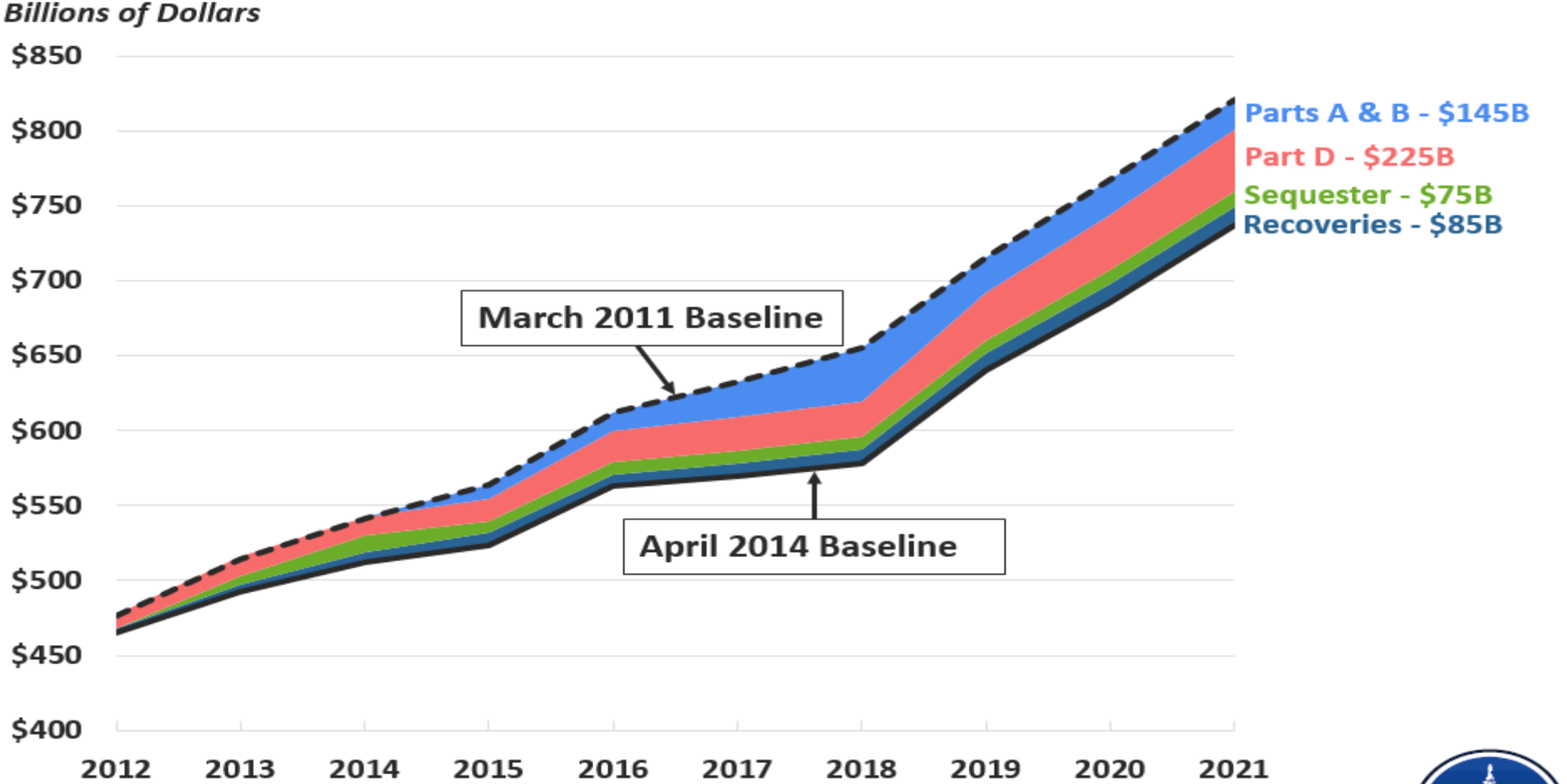
Note: n.m. = not meaningful; n.a. = not applicable; GSEs = government-sponsored enterprises, Fannie Mae and Freddie Mac.

CBO ACA Cost Estimates Revised Down



Budget Austerians say it's Part D, Which is Supposed to Mean Something

The \$530 Billion Medicare Slowdown



Source: Congressional Budget Office, CRFB calculations



Academics (summary by Mike Chernew in Health Affairs blog)

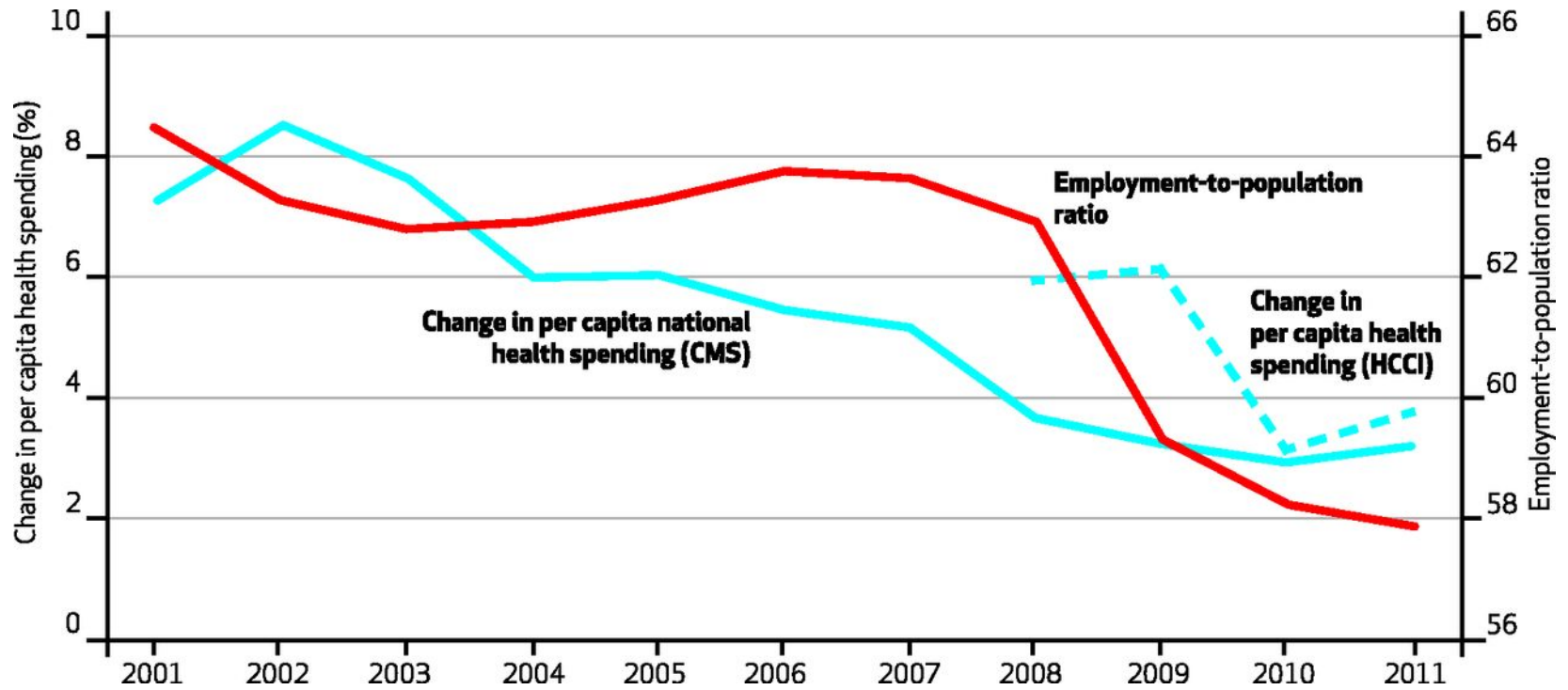
- **Competing Views On What Caused The Slowdown**

- The claim that the slowdown in spending was primarily attributable to the recession is controversial but there is certainly evidence to support it. [Dranove, Garthwaite and Ody](#) associate geographic variation in spending growth and employment to population ratios and conclude the economy played a major role in the spending slowdown. [Roehrig, Getzen and Altman](#) developed a model based on patterns of real GDP changes and inflation to predict the growth rate in health spending; using the model they conclude that over three-quarters (77 percent) of the recent slowdown in health spending growth can be attributed to changes in the economy.
- In contrast, [Chandra, Holmes and Skinner](#) argue that the Great Recession cannot be the main cause of the slowdown in health spending, as health expenditure growth during the recession was nearly the same as growth prior to the recession. Instead, these authors attribute the slowdown to the rise in high-deductible insurance plans, state-level efforts to reduce Medicaid costs, and a slowdown in the creation and uptake of new technology.

Academics (continued)

- **Competing Views On What Caused The Slowdown**
- [Cutler and Sahni](#) concur that the causes of the slowdown include a slower pace of technology creation and a greater prevalence of health plans that expose consumers to high cost sharing, in turn discouraging high health care utilization. These authors also attribute the slowdown to decreasing administrative expenses as medical records become increasingly computerized and standard operating rules increasingly govern the ACA and state legislation, and to better efficiency efforts — for example, the number of hospital-acquired infections is declining and there is greater emphasis on reducing readmissions.
- [Ryu et al.](#) similarly argue that factors leading to slower spending growth extend well beyond the recession, because spending growth of individuals who remained employed dropped precipitously, even when benefit generosity was held constant.

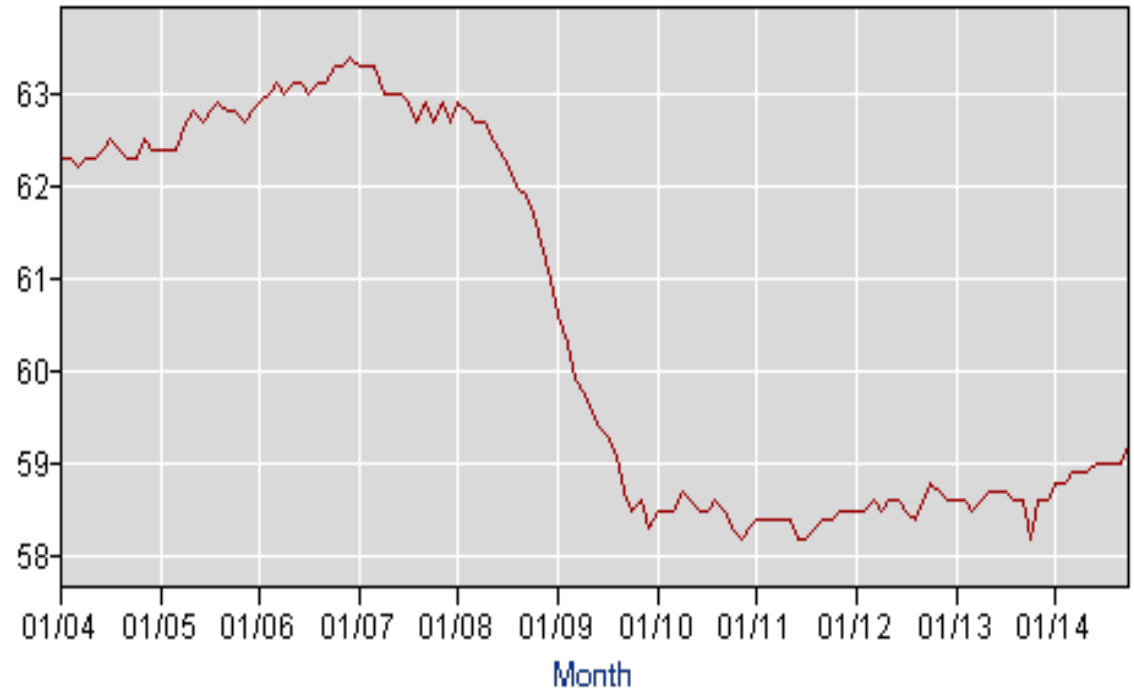
Per Capita Health Spending Growth And Employment-To-Population Ratio, 2001–11.



Dranove D et al. Health Aff 2014;33:1399-1406

HealthAffairs

BLS Employment to Population Ratio



Emmanuel Saez (UC Berkeley)

Table 1. Real Income Growth by Groups

	Average Income Real Growth (1)	Top 1% Incomes Real Growth (2)	Bottom 99% Incomes Real Growth (3)	Fraction of total growth (or loss) captured by top 1% (4)
Full period 1993-2012	17.9%	86.1%	6.6%	68%
Clinton Expansion 1993-2000	31.5%	98.7%	20.3%	45%
2001 Recession 2000-2002	-11.7%	-30.8%	-6.5%	57%
Bush Expansion 2002-2007	16.1%	61.8%	6.8%	65%
Great Recession 2007- 2009	-17.4%	-36.3%	-11.6%	49%
Recovery 2009-2012	6.0%	31.4%	0.4%	95%

Computations based on family market income including realized capital gains (before individual taxes).

Incomes exclude government transfers (such as unemployment insurance and social security) and non-taxable fringe benefits.

Incomes are deflated using the Consumer Price Index.

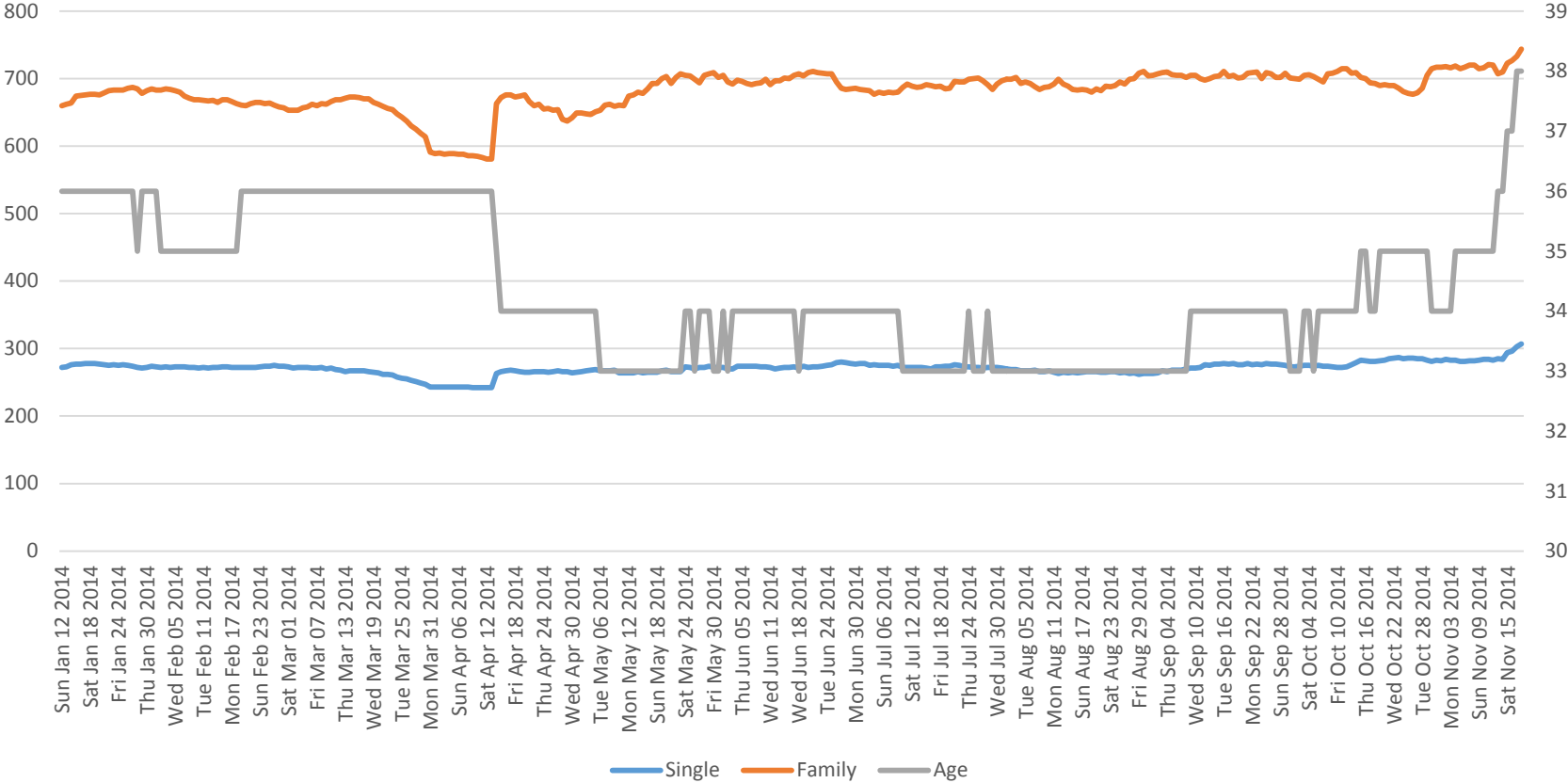
Column (4) reports the fraction of total real family income growth (or loss) captured by the top 1%.

For example, from 2002 to 2007, average real family incomes grew by 16.1% but 65% of that growth

accrued to the top 1% while only 35% of that growth accrued to the bottom 99% of US families.

Source: Piketty and Saez (2003), series updated to 2012 in August 2013 using IRS preliminary tax statistics for 2012.

ehealth daily premiums (left) age (right)



2014 Milliman Medical Index

By Christopher S. Girod, Lorraine W. Mayne, Scott A. Wertz,
Susan K. Hart | 20 May 2014

\$23,215. That's how much is spent in 2014 on healthcare for a typical American family of four covered by an average employer-sponsored health plan according to the 2014 Milliman Medical Index (MMI).¹ And yet while the amount has more than doubled over the past 10 years, growing from \$11,192 to \$23,215, the 5.4% growth rate from 2013 to 2014 is the **lowest annual change since the MMI was first calculated in 2002.**

S&P HEALTHCARE CLAIMS INDICES **June 30, 2014**

S&P Healthcare Claims National All Lines of Business Fee-For-Service Total Cost Index - % Change Year-over-Year

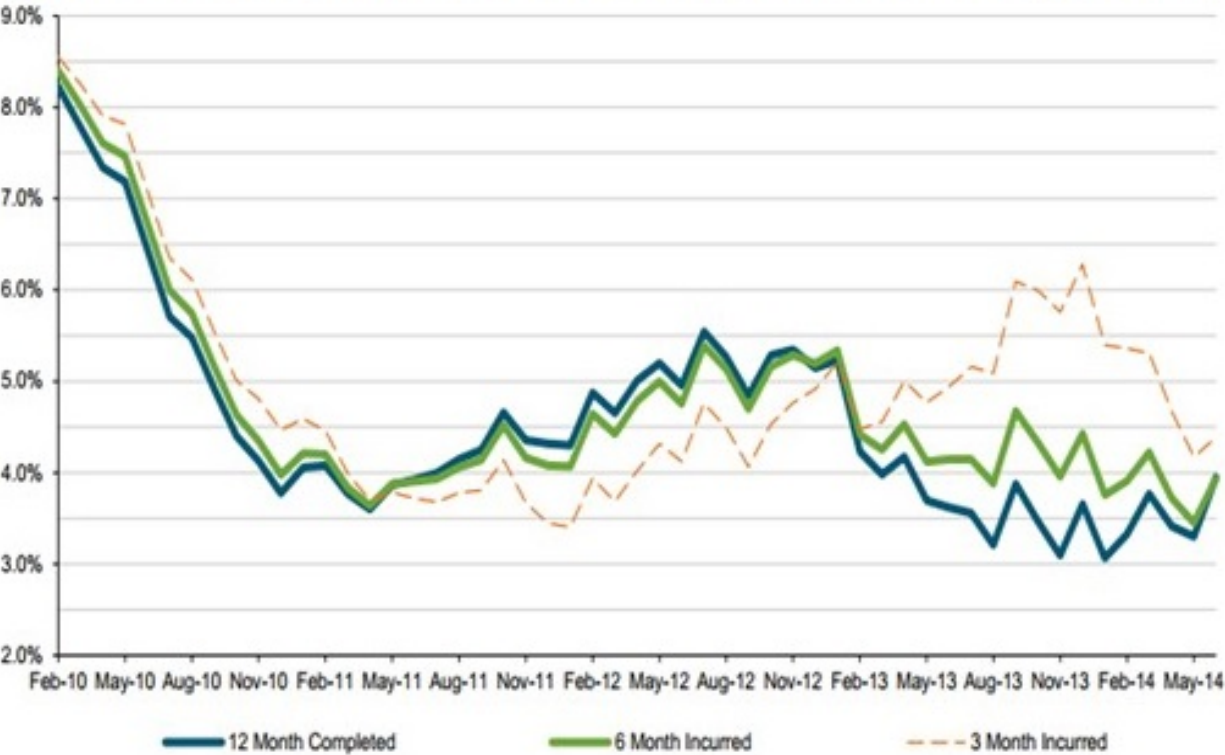
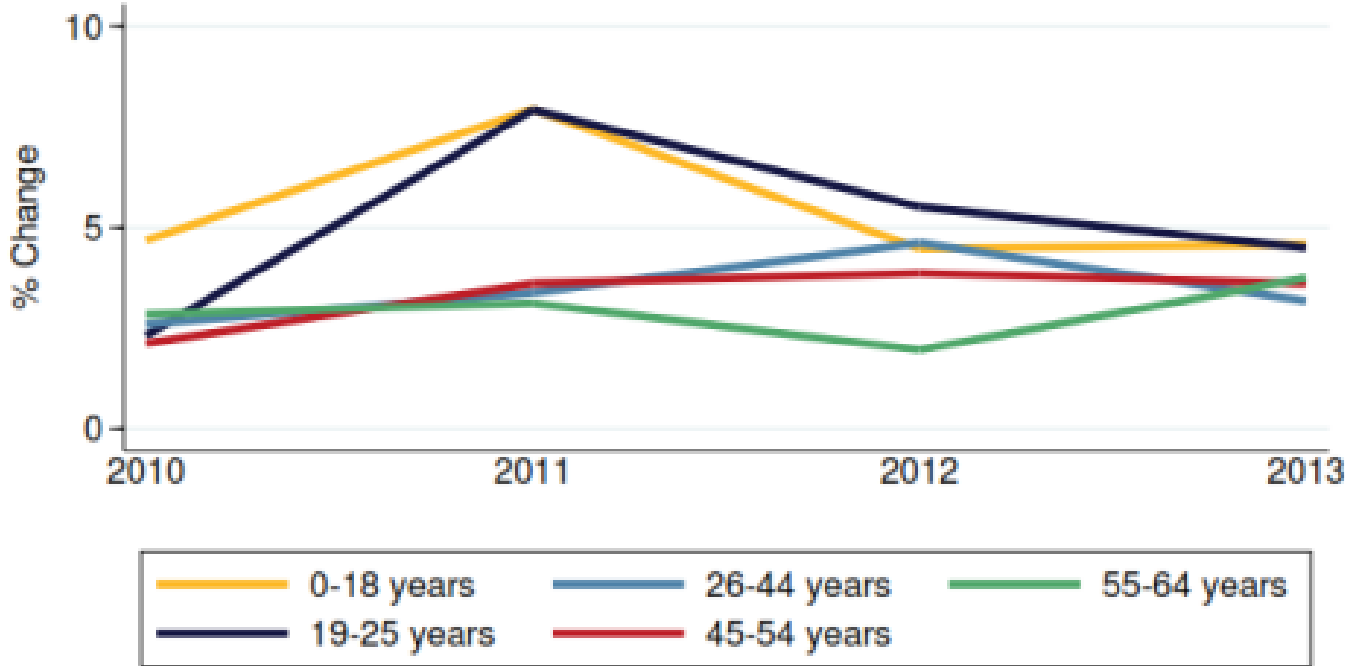


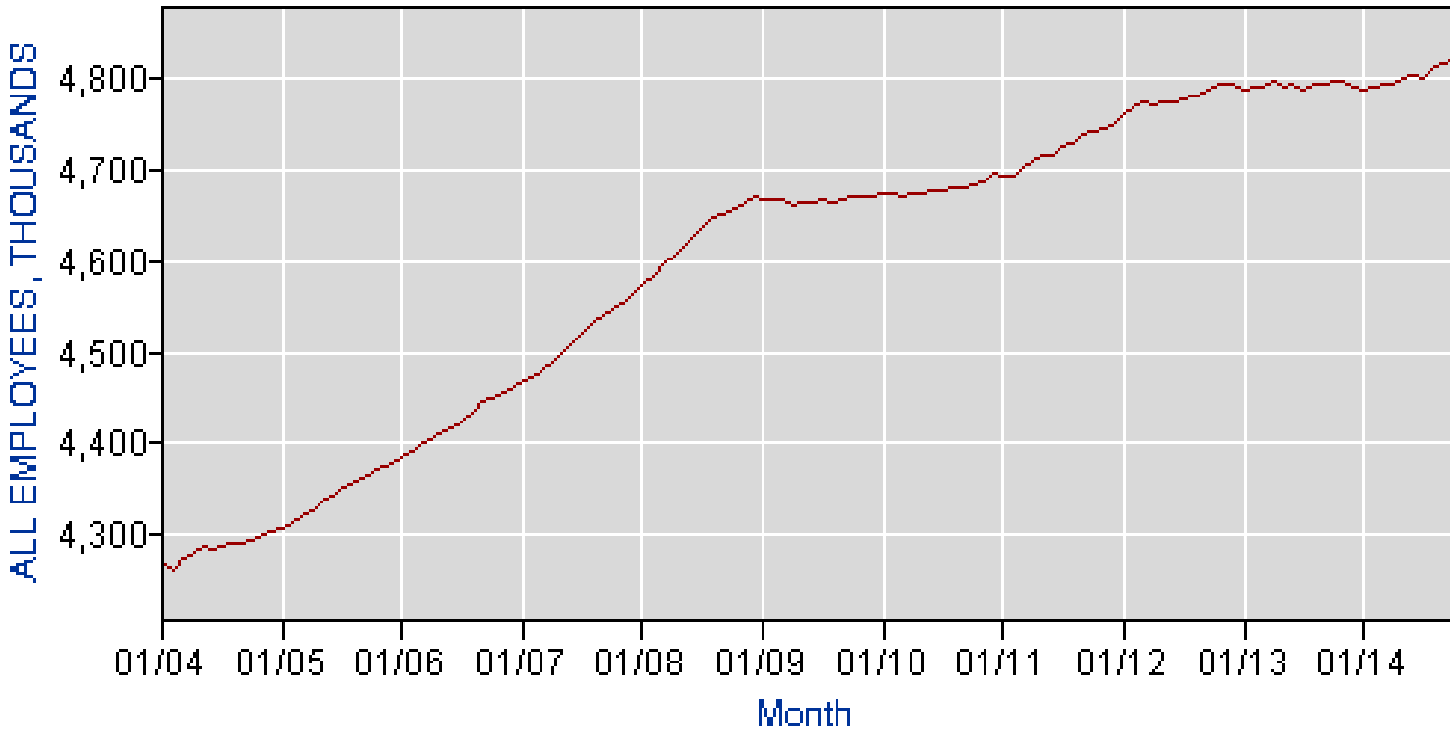
Figure 2
Annual Percentage Changes in Expenditures
Per Capita by Age Group: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

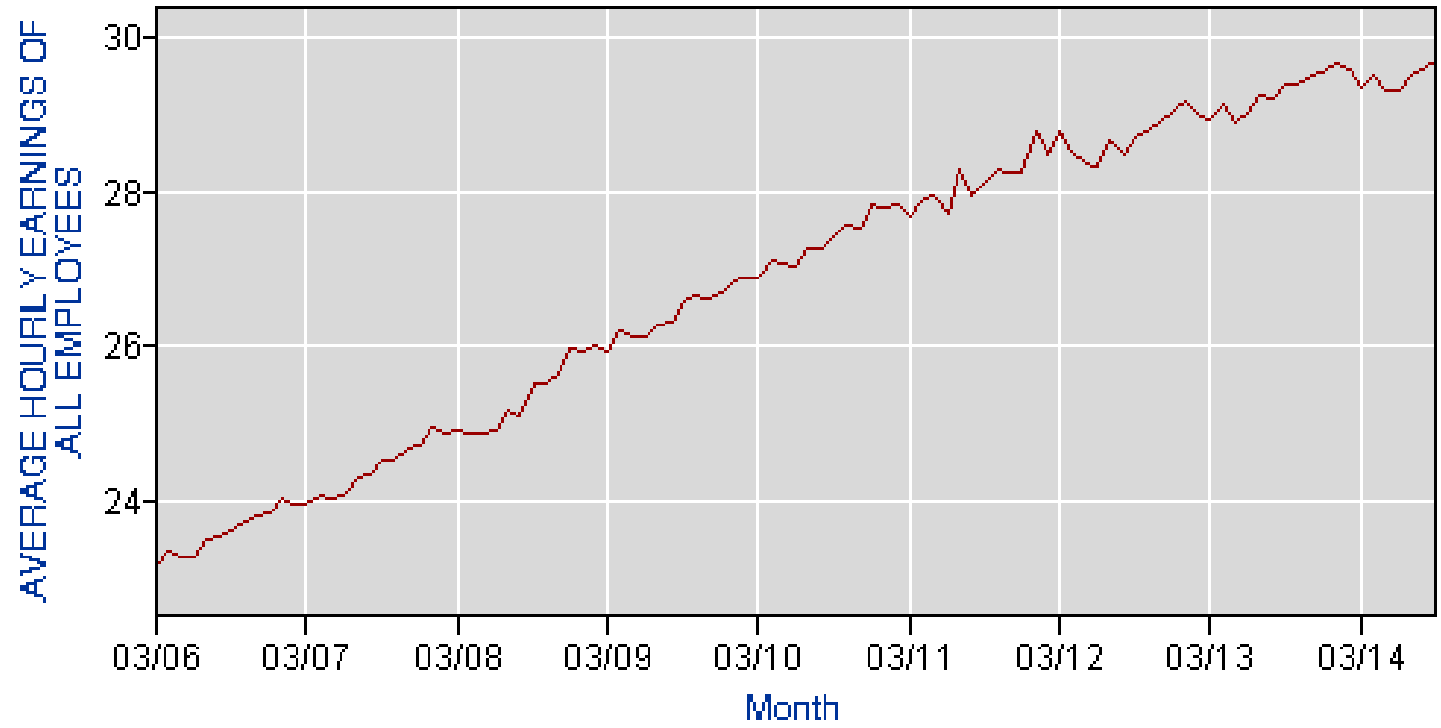
Supply Side – Employment Levels

Industry: Hospitals



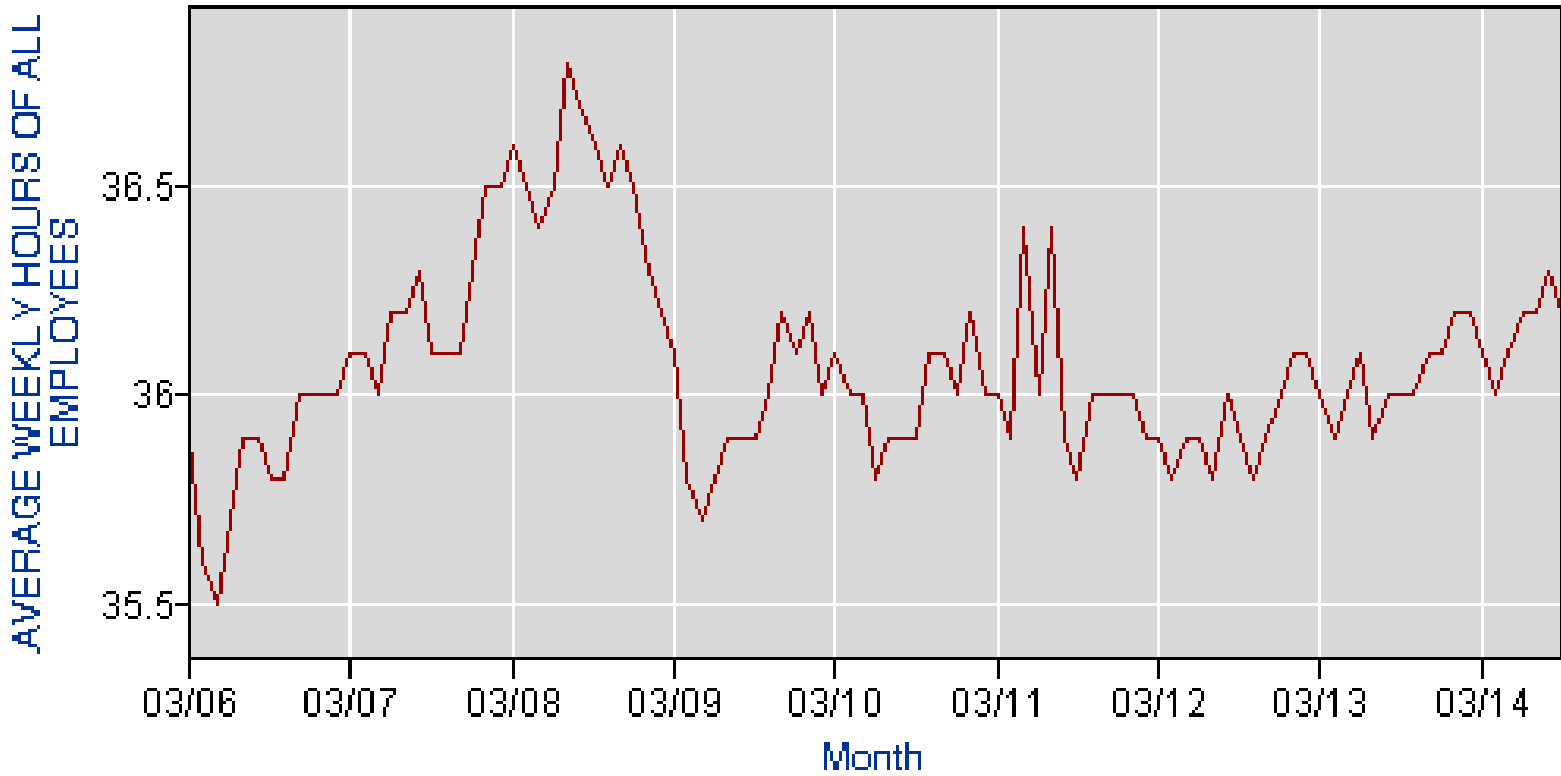
Average Hourly Earnings

Industry: Hospitals



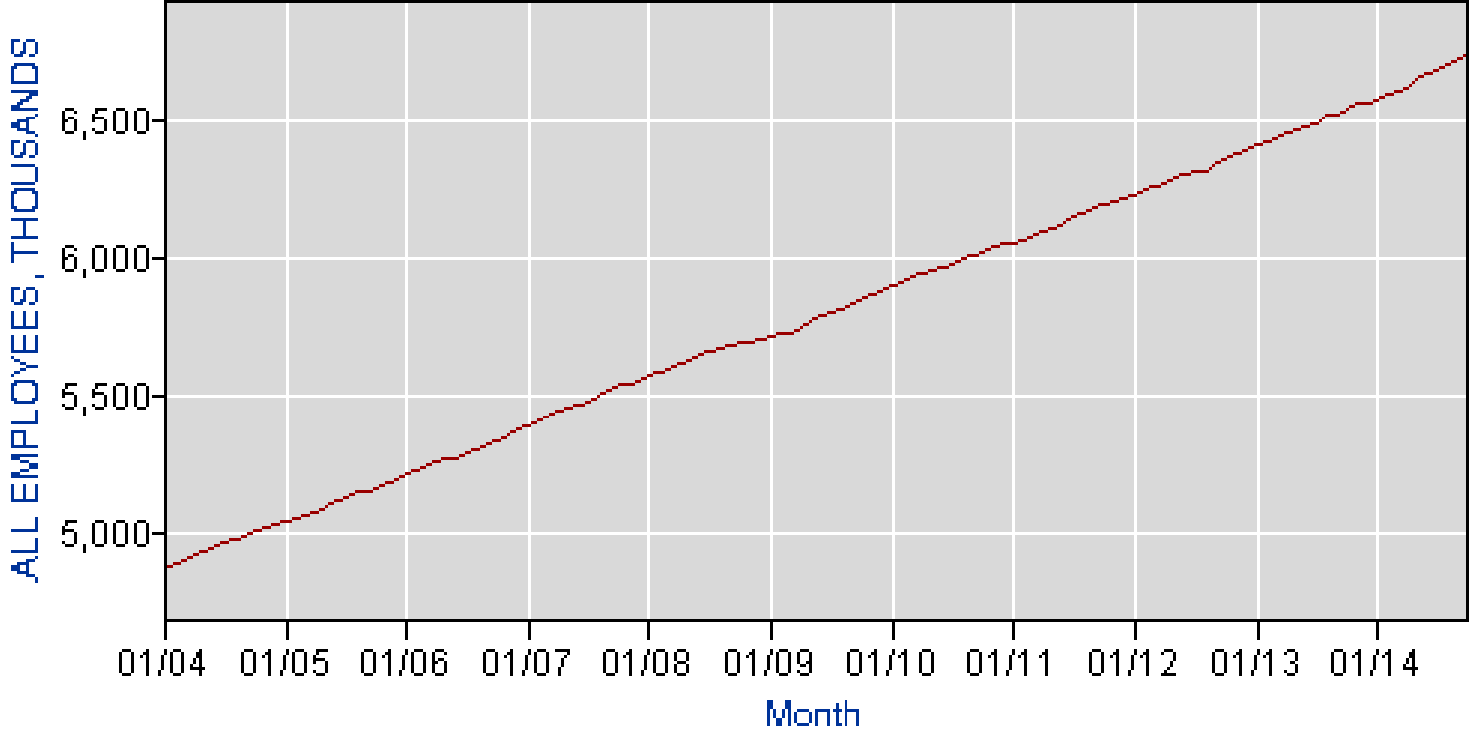
Average Weekly Hours

Industry: Hospitals



Employment

Industry: Ambulatory Health Care Services



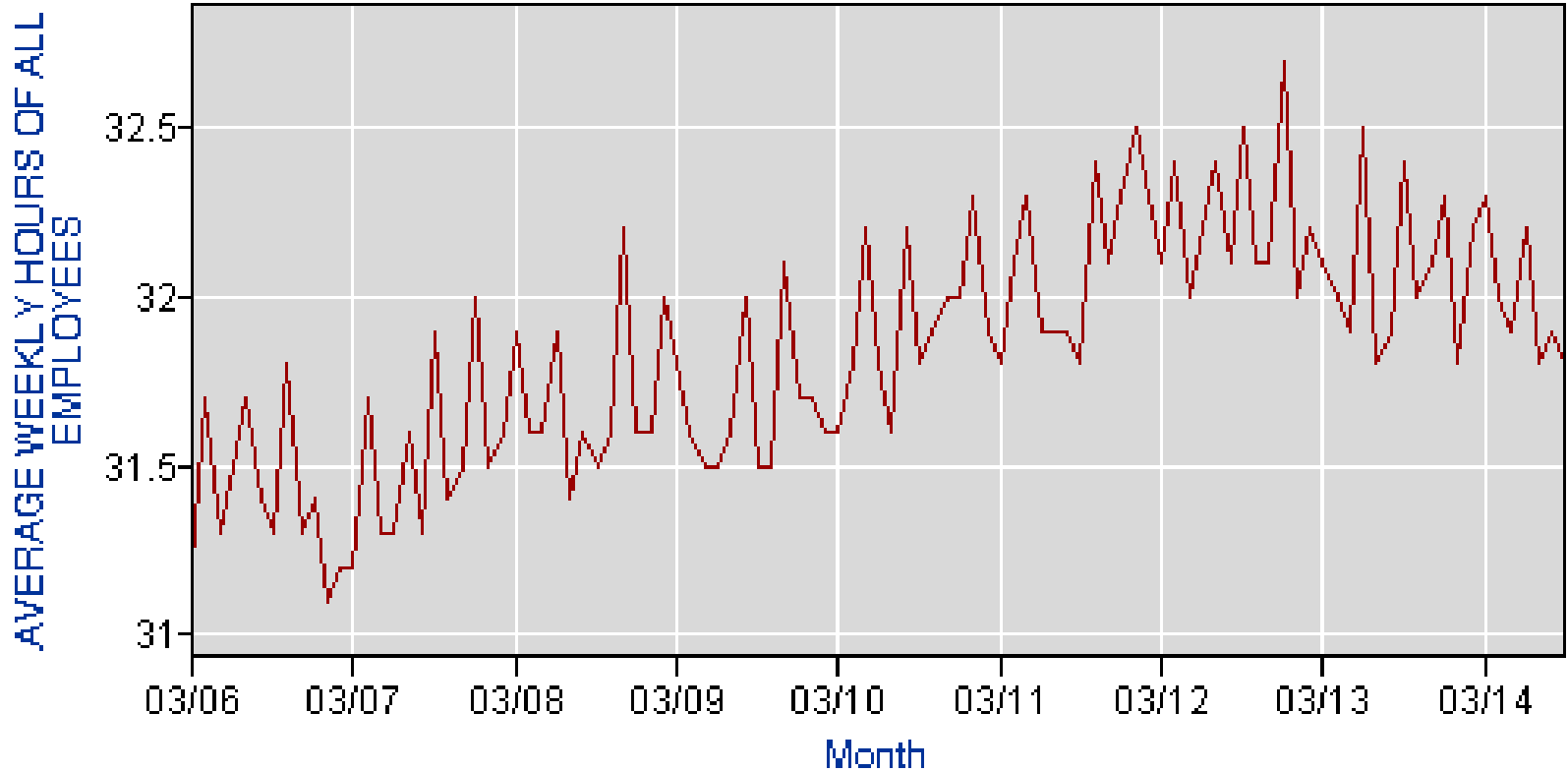
Average Hourly Earnings

Industry: Ambulatory Health Care Services



Average Weekly Hours

Industry: Ambulatory Health Care Services



Pundits – Hmmm... Seems Like More Than Just the Economy

TheUpshot

THE NEW HEALTH CARE

The Health-Cost Slowdown Isn't Just About the Economy

DEC. 5, 2014



David Leonhardt

@DLeonhardt

Email

Share

It's one of the most important economic questions today: Is the [snail-like growth](#) of health costs over the last several years a real trend, or is it merely a temporary part of the Great Recession's aftermath?

The data experts who compile [the government's official numbers](#) on health spending lean toward the more pessimistic view. They think the slowdown – to the lowest level of growth on record – stems in large part from Americans skimping on medical care during tough times.

“The pattern observed in recent years is not unique and is consistent with historical patterns,” Anne Martin of the Centers for [Medicare & Medicaid Services](#) said after that agency released new numbers this week. The agency's report put the argument this way: “The key question is whether

MetLife rescued more than 100,000 farms from foreclosure during the Great Depression and is now helping to be one of the nation's largest agricultural lenders today.

Insider Enthusiasts – **Measurements and Value Seeking Becoming the Unshakably Dominant Reality, not a Blip**

- Unauthorized lede quote from off-the-record presentation:
- "What really changed everything in the U.S. health system was Medicare's readmissions penalty..."

Readmissions – Clinical Measurement



The NEW ENGLAND JOURNAL of MEDICINE

SUBSCRIBE OR RENEW
Includes NEJM iPad Edition, 20 FREE Online CME Exams and more >>

SPECIAL ARTICLE [A Correction Has Been Published >](#)

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.
N Engl J Med 2009; 360:1418-1428 | April 2, 2009 | DOI: 10.1056/NEJMs0803563

Share: [f](#) [t](#) [+](#) [in](#) [+](#)

- Abstract
- Article
- References
- Citing Articles (881)
- Letters

BACKGROUND

Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs. However, we have limited information on the frequency and patterns of rehospitalization in the United States to aid in planning the necessary changes.

[Full Text of Background...](#)

METHODS

2003–2004 to describe the

MEDIA IN THIS ARTICLE

FIGURE 1



Rates of Rehospitalization within 30 Days after Hospital Discharge.

FIGURE 2



TOOLS

- PDF
- Print
- Download Citation
- Slide Set
- Supplementary Material
- E-Mail
- Save
- Article Alert
- Reprints
- Permissions
- Share/Bookmark

RELATED ARTICLES

EDITORIAL
Revisiting Readmissions — Changing the Incentives for Shared Accountability
April 2, 2009 | A.M. Epstein

CORRESPONDENCE
Rehospitalizations among Patients in the Medicare Fee-for-Service Program
July 16, 2009

CORRECTION

Readmissions – Comparative Measurement

Greater Greater Washingt... | Inbox (417) - jlemieux256@... | Hospital Readmission Rates in Medicare Advantage Plans

www.ajmc.com/publications/issue/2012/2012-2-vol18-n2/Hospital-Readmission-Rates-in-Medicare-Advantage-Plans/

Apps | CAQH - Data Access...

Login | Register | E-mail Signup | Search

About Us | Publications | AJMC TV | Events | Conferences | News | Authors | Essentials | CE | Research | ACO Coalition

Advertisement

AJMC.com
Managed Markets Network

Trulicity™ is a glucagon-like peptide-1 receptor agonist (GLP-1 RA) that is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.
Limitations of Use: Not recommended as first-line therapy for patients inadequately controlled on diet and exercise. Has not been studied in patients with a history of pancreatitis; consider another antidiabetic therapy. Not for the treatment of type 1 diabetes mellitus or diabetic ketoacidosis. Not a substitute for insulin. Has not been studied in patients with severe gastrointestinal disease, including severe gastroparesis. Not for patients with pre-existing severe gastrointestinal disease. Has not been studied in combination with basal insulin.

Safety and Boxed Warning
lifetime exposure. It is unknown whether Trulicity causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance could not be determined from clinical or nonclinical studies.

Full Prescribing Information | Medication Guide

AJMC.com - Managed Markets Network

AJMC

Facebook | Twitter | LinkedIn | Pinterest | Google+ | Email

Hospital Readmission Rates in Medicare Advantage Plans

Published Online: February 27, 2012

Jeff Lemieux, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA

Objectives: To compute a benchmark for tracking readmission rates among patients enrolled in Medicare's private comprehensive Medicare Advantage (MA) plans and to develop preliminary comparisons with the fee-for-service (FFS) readmission rates.

Study Design: Descriptive data presentation with analytic discussion.

Methods: We computed a benchmark for rehospitalization rates among MA patients using data from a commercial registry. To compare readmission rates between FFS and MA patients, we analyzed differences in demographics, geography, time period, entitlement status, and risk of readmission based on major diagnosis associated with the admission and the presence of complicating conditions.

Advertisement

What makes atrial fibrillation and venous thromboembolism so hard to manage?

The Listen Mission
You talk. We listen.

Issue: February 2012

CLINICAL

Nurse-Run, Telephone-Based

www.ajmc.com

Transaction details.xlsx | 2014 Index Report S...docx

Show all downloads

5:49 | 12/7

Readmissions – Measurement and Value Seeking

Greater Greater Washingtc x | Inbox (417) - jlemieux256 x | Medicare Advantage Chro x

content.healthaffairs.org/content/31/1/110.abstract

Apps | CAQH - Data Access...

Conversations Podcast

Health Affairs Blog Editor Chris Fleming hosts timely roundtable discussions about various aspects of ACA implementation.

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

SEARCH Advanced Search »

HealthAffairs

FOLLOW US      

HOME | ABOUT | ARCHIVE | TOPICS | BLOGS | BRIEFS | THEME ISSUES | SUBSCRIBE | ALERTS | MY ACCOUNT

Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients Expand

Robb Cohen¹, Jeff Lemieux², Jeff Schoenborn³ and Teresa Mulligan⁴

+ Author Affiliations

Abstract

The Affordable Care Act of 2010 authorized the continued availability of Medicare Advantage Chronic Condition Special Needs Plans (C-SNPs). This case study examines the model of care used by the largest such plan, Care Improvement

« Previous | Next Article »
Table of Contents

This Article

doi: 10.1377/hlthaff.2011.0998
Health Aff January 2012 vol. 31 no. 1 110-119

» Abstract
Full Text
PDF
Appendix
Erratum

Classifications
Medical Management & Care

Services
Email this article to a colleague
Alert me when this article is cited
Alert me if a correction is posted
Alert me when new responses are published

CURRENT ISSUE

VOL. 33 | NO. 11
November 2014

Collaborating For Community Health



Alert me to new issues of Health Affairs

- From The Editor-In-Chief
- Entry Point: Past Hospital Walls
- Putting Health In Communities
- Using Pay-For-Success
- Wellness Measures In Real Estate
- The Child Opportunity Index
- Pharmacy Deserts In Chicago
- Housing Code Violations And Asthma
- Specialty Drug Spending Trends

content.healthaffairs.org/content/31/1/110.full

Transaction details.xlsx | 2014 Index Report S....docx

Windows taskbar with icons for Internet Explorer, File Explorer, Google Chrome, Microsoft Word, and PowerPoint. System tray shows network and volume icons.

Future of Health Care? **Measurements and Value Seeking**, both Clinical and Business. (Hopefully)

Table 9. DRAFT Electronic Transaction Adoption Rates, Comparable Health Plans, 2012 and 2013
(percent of transactions)

	Fully Electronic (Standardized)		Fully Manual (Phone, Fax, Mail)		Partially Electronic (Web Portal, IVR)	
	2012	2013	2012	2013	2012	2013
Claim Submission	90%	92%	10%	8%	NA	NA
Eligibility and Benefit Verification	63%	64%	4%	4%	34%	32%
Prior Authorization	*	7%	*	36%	*	57%
Claim Status	48%	50%	9%	8%	43%	43%
Claim Payment	50%	57%	50%	43%	NA	NA
Remittance Advice**	43%	46%	50%	42%	8%	12%

Source: CAQH Index. All responding health plans.

Note: NA = not applicable.

*Incorporated into the main CAQH Index data collection process for 2013 data, breakdown for 2012 not available.

**2012 RA adoption percentage was revised slightly for consistency with the 2013 figures.