



Cutting Red Tape in Health Care

How Streamlining Billing Can Reduce
California's Health Care Costs

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July 2009

Acknowledgments

The authors wish to thank Jan Root of the Utah Health Information Network, Sira Cormier of the New England Healthcare EDI Network, and Leif Haase and Micah Weinberg of the New America Foundation for their review of this report. Thanks to Tony Dutzik and Elizabeth Ridlington of Frontier Group for their editorial assistance. The generous financial support of the California Wellness Foundation made this report possible.

The authors bear responsibility for any factual errors. The recommendations are those of CALPIRG Education Fund. The views expressed in this report are those of the authors and do not necessarily reflect the views of our funders or those who provided review.

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Executive Summary

California's health care system is broken. Costs are rising faster than either inflation or wages, and wasteful spending is a major culprit. Inefficient and duplicative administrative systems force doctors and hospitals to spend more time and money on administrative support than is necessary, which increases costs to patients.

However, by following the example of other states and streamlining key processes—such as insurance billing and payment and physician credentialing at hospitals—providers and payers in California can collectively save hundreds of millions of dollars annually and help lower the cost of health care.

Complicated billing practices and administrative systems result in grossly inefficient communication between physicians, hospitals and insurers and lead to higher-cost care for patients.

- Physicians' offices spend large amounts of administrative time on getting paid for the care they provide. In California doctors' offices, billing

and insurance-related costs account for more than half of all administrative spending, or 14 percent of total office revenues.

- Insurers share the burden of inefficient administrative processes. In California, 21 percent of private insurer health care spending goes to billing and insurance-related costs instead of direct patient care. This is the rough equivalent of \$9 billion, or 5.4 percent of total yearly health care spending statewide.

In several states, integrated health information networks are helping health care providers and payers increase efficiency and cut costs, with important benefits to consumers.

- Utah's health information network has been active since 1993, and reduces costs by empowering a public-private partnership to operate a computerized system that serves as a common intermediary between providers and insurers. The Utah network has:

- o *Boosted the efficiency* of the health insurance billing and claims processes for the 95 percent of Utah physicians and 100 percent of Utah insurers, laboratories and hospitals that participate in the network, increasing processing speeds to more than 6 times the national average; and
- o *Reduced transaction costs* on average to less than 5 cents per transaction for its members.
- In New England, a multi-state consortium embraced federal regulations and achieved administrative simplification by creating a network that functions as an information pipeline. In just over a decade, the New England network has:
 - o *Connected the payers and providers* who serve more than 2.5 million residents;
 - o *Cut the cost of sending claims-related information*, resulting in savings of \$1 million in one year for a large provider group (and more in some cases); and
 - o *Generated returns on new-member investment* in a period of less than one year.
- *Actively encouraging the formation of a health information network similar to the Utah and New England examples.* The network would be operated on a non-profit basis, and would be funded and governed by participating health care entities. Members would receive equal returns on investment, preventing any one business from gaining a competitive edge. All members would generate significant cost savings from the enterprise, which could be established in parallel with the adoption of further technology-related health care reforms.
- *Providing short-term, low-interest loans to needy parties.* While most healthy businesses will be able to make the small investments necessary to operate a California health information network, the state can help finance the investments of struggling providers by granting small, low-interest loans in cases of proven need.
- *Implementing complementary health care reforms.* The efficiencies gained through a health information service would help and be helped by related health care policies. A standard requiring health insurance companies to spend a minimum percentage of revenues on care, for example, would incentivize participation in an information network that reduces overhead costs in the long run. Similarly, a health information network would provide the mechanism for a secure yet modern exchange of health data, such as electronic medical records.

By following the lead of other states and streamlining health care administrative practices, California can help fix its broken health care system and save consumers money. It can accomplish this by:

Introduction

When it comes to paying for health care, Californians are feeling the pinch. In communities around the state, many families are putting off routine medical checkups and trying to find non-clinical ways to stay healthy in the hope that they can trim costs and avoid expensive doctor's visits. A recent study from the Harvard School of Public Health found, for example, that 45 percent of Americans have taken action to reduce the costs of their health care over the past year, including forgoing recommended care.¹

Spiraling costs are one of the most visible problems in California's broken health care system. Between 2000 and 2004, the cost of a typical doctor's visit rose an average of 21 percent for Californians. The average cost of hospital care rose 26 percent and home health care costs jumped by a staggering 62 percent.² Consumers feel the impact in their pocketbooks, as insurance costs rise sharply in response.

At the same time, wages can't keep pace with rising costs. Real wages in California increased only 3.5 percent between 2001 and 2004, compared to the nearly 21 percent increase in health care costs.³ In tough times, the financial strain on

consumers is particularly taxing, and Californians around the state are being forced to make tough choices about their personal health and the health of loved ones. A recent study from researchers at Harvard University found that as many as 62 percent of all bankruptcies in America in 2007 involved medical debt, and stories of families bankrupted by illness and of elderly patients having to choose between life-giving prescriptions and food are becoming increasingly common.⁴

California can do better. There are many smart and straightforward ways—including efforts that have proven successful in other states—to reduce the burden of health care costs, both now and over the long haul. This report describes initiatives elsewhere in the United States in which insurers and health care providers have put aside their individual imperatives in order to work together to improve administrative efficiency in health care. The results are financial savings and more efficient organizations. The state of California can do its part in capturing similar benefits by enacting key policies, also outlined here.

California's health care system is in for dramatic changes. Reforms under

discussion at the state and federal levels, coupled with new administrative rules and the move toward electronic health records, create a new—but potentially fleeting—

opportunity. The state can act now to streamline health care administration, a move that will save money for years to come.

Administrative Inefficiencies Account for Significant Health Care Waste in California

Some administrative costs in the health care industry are necessary and provide benefits to patients. When well executed, functions such as billing, information technology support, and insurance eligibility verification help to deliver efficient and high-quality health services. However, many administrative processes are duplicative and unnecessary, and result in higher costs to patients.

Take, for instance, a middle-aged woman who goes to her doctor's office with early symptoms of heart disease. Once her symptoms are diagnosed, office staff will have to spend time determining what kind of care is covered by her insurance. To prescribe a cholesterol medication, the woman's doctor may spend time looking up which drugs are covered by her insurance plan, and determine the amount of the co-pay for the drug. In many cases, however, her doctor might be too busy to check, and the woman would not find out that her drug was not covered until she got to her pharmacy. This could then cause a lengthy back-and-forth between her doctor and pharmacist, for which neither would be compensated.

Then, in order to be paid for the care

the woman received, her doctor's staff must complete billing forms that require specific coverage information to be provided. Despite a limited degree of federal standardization, this information is coded in different ways, depending on both her insurance company and on the specific benefits and co-pays of her insurance plan. Accurately completing the forms demands large amounts of staff time, and may require the services of billing specialists or claims clearinghouses—at additional cost to the doctor.

Once the woman's claim has been successfully completed, it must be submitted to her insurer. In some cases it might be submitted electronically; in others, the claim might be written or printed and then faxed. The woman's insurer then has to pay someone to handle the received form and send it to the correct internal location, a process whose efficiency varies greatly by insurer. Meanwhile, her doctor's office must use staff time to track the claim and ensure it gets paid, and deal with the fact that each service on the woman's claim may have a different payment schedule, divided into three parts: what the insurer pays, what the woman pays, and what the

doctor has agreed to cover. The woman herself may not learn for weeks whether or not her claim has been accepted.

Further, if there is any dispute between the physician and the insurer, it is the patient who will have to take the time to sort out the mess—a frustrating and often time-consuming process.

The costs of these many steps, repeated for hundreds of patients per week in thousands of clinics around the state, add up quickly. In California doctors' offices, billing and insurance-related costs account for more than half of all administrative spending, or 14 percent of total office revenues.⁵

The costs of billing and claims processing are not limited to physicians alone: insurers and hospitals share the burden of these labyrinthine administrative processes. In California, 21 percent of private insurer health care spending goes to administrative costs instead of direct patient care.⁶ This is the rough equivalent of \$9 billion, or 5.4 percent of total yearly health care spending statewide.⁷ Hospitals bear fewer (though by no means negligible) costs, at 7 to 11 percent of their total revenues.⁸

California consumers have a clear interest in more efficient health care administration.

The cumbersome complexity of our billing and administrative processes is obvious in even one visit to the doctor—and consumers pay the price of these inefficiencies in the form of high health care costs, from the prices of insurance premiums to fees for doctors' visits and lab work to the reduced time doctors have to spend with their patients.

Further, having to wait 45 days—the national average wait time for insurance claims—to learn whether an insurer has fully covered a procedure is worrisome to patients, and not knowing when a bill might arrive creates difficulties for family budgets. Waiting to get an important procedure or drug while attempting to sort out insurance eligibility can be unhealthy and even dangerous.

Cutting administrative costs would likely result in consumer benefits—particularly if insurers are held to a higher efficiency standard for overhead spending—and more efficient claims processing could also help provide better care and peace of mind. By taking steps to curb these inefficiencies among providers and insurers alike, California can reduce the high cost of administering health services and help make health care affordable for Californians.

Improving Administrative Efficiency

Administrative efficiency in health care breaks down to three key problem areas: locating, coding and inputting information; checking to make sure the inputs are correct; and transferring claims information between providers and payers. These processes are necessary, and California's health care system has attempted to deal with them by developing internal billing and verification systems that are generally unique to each provider and insurer; by hiring billing specialists; and by using the services of claims clearinghouses. But these steps are, by and large, more inefficient and expensive than they need to be.

Prompted by the shared goal of efficiency, payers and providers in several states have joined together to fund and govern administrative information exchange networks. Two of the most comprehensive and long-lived of these networks operate in Utah and New England, and, though the solutions they offer are unique to the regions they serve, both provide examples of how California can streamline health care administration.

Utah's Health Information Venture: Finding Efficiency and Adding Value

The non-profit Utah Health Information Network (UHIN) was created in 1993, following passage of a state law that required insurers to accept administrative files in a state-standardized format.⁹ A collection of health care payers and providers each contributed \$25,000 to found the organization, and in exchange gained a voting seat on the UHIN board.¹⁰ The organization's financial support continues to come from its members. Rather than seeking to regulate or monitor the flow of health information, UHIN is designed to add value to the businesses and organizations it serves.

Day-to-day, UHIN serves as an information pipeline between members of Utah's health care community, including insurers, providers, laboratories, pharmacies, hospitals and the Department of Health. UHIN first provides a federally-compliant standard format for billing and credentialing paperwork, so that, for

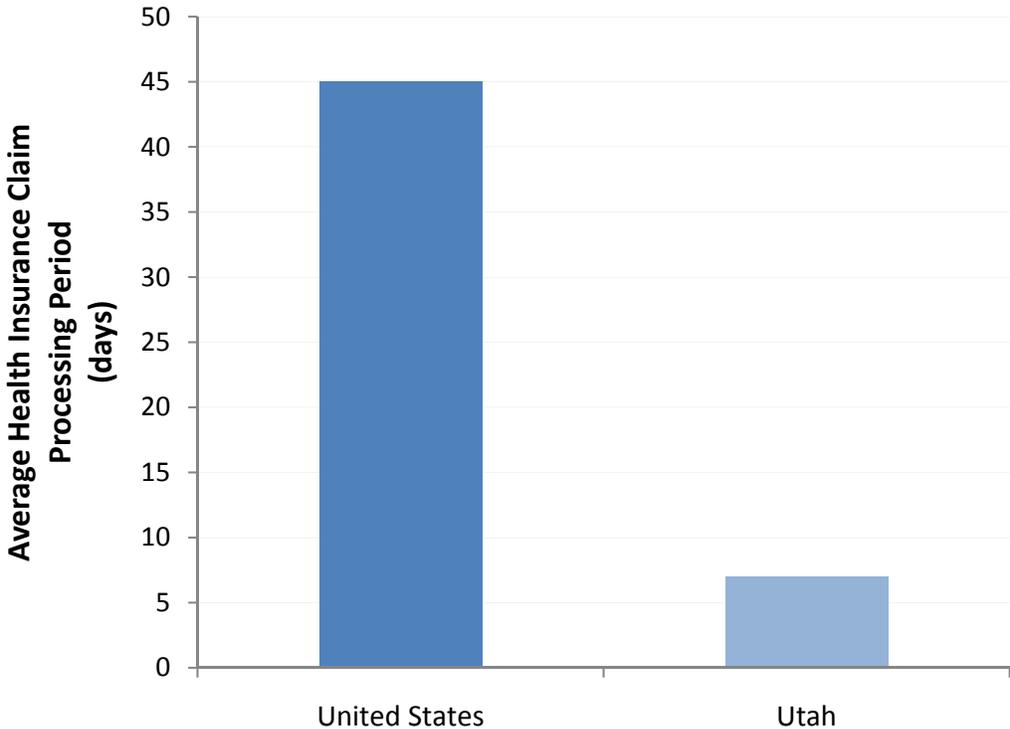
example, physicians can use a single form, with a unified set of codes, to make insurance claims to multiple payers, instead of submitting a different type of form to each insurer. The group then delivers this private information over a secure network accessible only by participating organizations and businesses.

Over the years, UHIN has grown under its policy of open governance, in which financially invested participants play a major decision-making role. Cooperation among board members is encouraged by the fact that the board members do not police one another, since UHIN plays no role in evaluating or regulating the pieces of information that flow along its network. At the same time, UHIN's policy of "equitable pricing," which works to ensure that all participants gain roughly the same value from UHIN membership, helps participating parties get equal return on equal investment.¹¹

This combination of shared investment, power and dividends appears to have played a major role in attracting the broad participation that UHIN enjoys. Though Utah's health care system is by no means as large as California's, all of Utah's hospitals, health plans, laboratories, local health departments and mental health centers were connected and/or sent claims through UHIN by 2006, as well as 95 percent of physicians and even 90 percent of chiropractors statewide.¹²

Accessible software is a key component of UHIN's high participation rate among clinicians. UHIN provides a computer program that allows any clinician with an internet connection to participate in electronic billing. Since approximately half of the clinicians in Utah work in small offices with small IT investments (and often little to no regular IT support), UHIN's user-friendly software has enabled more small providers to participate in the network.¹³

Figure 1. Average health insurance claim processing period, national average versus Utah¹⁹



Profile in Efficiency: Utah Health Information Network (UHIN)

System: Standardized billing forms transmitted via secure computerized network

Governance: Non-profit, small full-time staff, stakeholder board of governors

Funding: Member fees

Population served: 2.6 million residents

Results:

- Close to 100 percent participation by hospitals, insurers, physicians, laboratories and pharmacies statewide
- Average costs of less than \$0.05 per transaction
- Claims processing six times more efficient than national average

Key to Success:

- Member investment through open governance, member financial investment
- Equal stakeholder return
- Secure network
- State law requiring insurers to accept universal forms

One result of wide participation has been large benefit to payers, providers and consumers alike. Today, UHIN transmits more than 30 million health care transactions each year, and reduces costs for participants to an average of 5 cents per transaction.¹⁴ Provider fees range from \$240 annually for one-clinician offices to \$33,000 annually for large integrated health delivery systems.¹⁵ Reducing costs even close to this level would be a boon for California's health care industry, since many clearinghouse transactions can easily cost 35 cents or more each.¹⁶

Claims processing in Utah is now more than six times more efficient than the national average, requiring an average of just seven days compared to 45 days nationally.¹⁷

(See Figure 1.) Consumers benefit from fast processing in greater peace-of-mind, learning quickly whether their insurers have covered a procedure so that they do not have to worry about a surprise medical bill.¹⁸

Part of UHIN's success is tied to its ability to build consensus. Many health information networks established at roughly the same time as UHIN stumbled for lack of a viable business model or sufficient cooperation among the various parties. Utah's legislature, however, incentivized cooperation by requiring insurers to accept state-created universal forms (beyond the eight now required under federal law), a step that could prove useful in California's efforts to improve administrative efficiency.

“Claims processing in Utah is now more than six times more efficient than the national average.”

The New England Healthcare Electronic Data Interchange Network: Anticipating and Improving on Federal HIPAA Requirements

In 1996, Congress passed a major health care package, the Health Insurance Portability and Accountability Act, known as HIPAA. Among its many provisions, HIPAA required payers to use standardized forms and codes for a specific set of common transactions (including billing, payment, and insurance eligibility information, among others), with an initial 2003 deadline.²⁰ While most players in the health care industry viewed HIPAA as a bureaucratic requirement, New England saw it as an opportunity. When final HIPAA compliance came due in 2004 (2005 for some areas of the health care field), New England found itself in automatic good standing and operating with a health information network that in fact improved on the efficiencies HIPAA originally sought.

With HIPAA requirements on the horizon, a group of competing New England-based payers and providers founded the New England Healthcare Electronic Data Interchange Network (NEHEN) in 1997. The group perceived that its members could collectively reduce costs without giving any one member a competitive advantage, since each member bore administrative transaction costs and reducing them would result in proportional benefit to each party.

Like the Utah network, NEHEN operates as a non-profit organization that is funded and governed by its members and serves as an information pipeline. Its secure network requires only that members transmit information in a standard, HIPAA-compliant format, and does not store or evaluate the data that it moves.

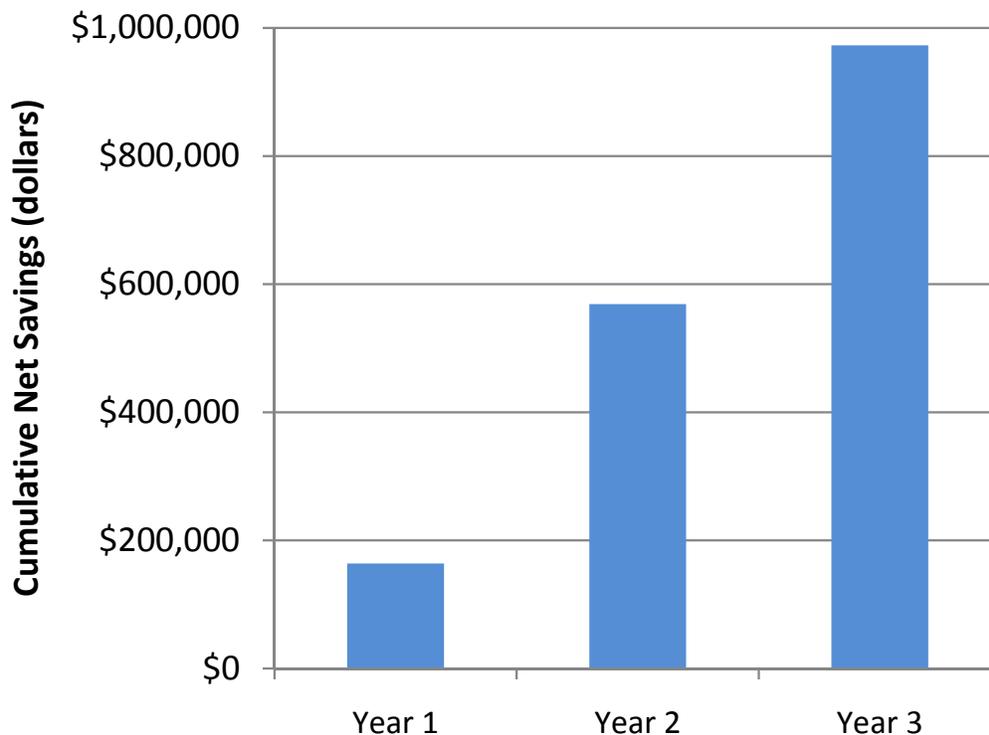
However, NEHEN differs from the Utah model in that it offers two packages to its members. NEHEN Classic, at first the only interface NEHEN offered, adapts to a user's existing systems and requires users to have sophisticated in-house information technology capacities. Its user fee is higher, but grants the user ownership and voting rights within the organization. NEHEN Classic is therefore most appealing to larger payers and provider groups. To meet the needs of smaller members, NEHEN introduced the NEHEN*Net* in July 2007. NEHEN*Net* is a web-based application that requires far less technological sophistication to access, though it does not integrate into an organization's existing computer systems. NEHEN*Net* members pay less for the service, but do not hold a NEHEN vote.²¹

NEHEN's daily operations are run by a third party, the Computer Science Corporation. Its elected Board of Managers is comprised of member organizations and non-voting representatives from health agencies. Member groups provide all funding for the organization based on a system of graduated fees, ranging from \$12,000 per year for a small lab or pharmacy to \$180,000 per year for a large insurer with more than 2 million members.²²

With a critical mass of large insurers and providers on board from the start, NEHEN quickly picked up momentum that attracted other health care players. In the decade following its 1997 inception, NEHEN grew to serve a total of more than 46 hospitals, 5,000 physicians, 2.5 million health plan members, six health plans (and one local insurer), and eight national insurers through local affiliates.²³ By 2006, the network was processing more than 4.5 million transactions every month, and 80 percent of all transactions in Massachusetts, where the network is based.²⁴

As in the Utah example, intensive use by a large portion of the region's health care industry has helped NEHEN significantly

Figure 2. Cumulative net savings in first three years of membership for a NEHEN health care provider group of more than 200 physicians²⁹



cut costs for its members. For example, the health care provider Baystate Health became a NEHEN member in 2007 and had saved more than \$1.5 million by April 2009 through lowered transaction fees.²⁵ By and large, NEHEN helps accomplish these savings by trimming the amount of money member organizations have to spend on labor to process billing and claims-related information.²⁶ NEHEN also improves the success rate on claims-related and co-pay collections.

The combined result of labor cost savings and improved collections returns money to the average NEHEN member, even when network fees and startup implementation costs are taken into account.²⁷ A large provider group of 200 or more physicians, for instance, can net cumulative savings of close to \$1 million within

its first three years of joining NEHEN.²⁸ (See Figure 2 and Table 1.)

Unlike Utah's network, NEHEN does not seek to streamline the process of obtaining hospital and insurer credentials for physicians—another key area for gaining efficiency. While it has existed for a shorter period of time, NEHEN is also less comprehensive in terms of member participation. However, when HIPAA compliance became mandatory in 2004, NEHEN members were ahead of the game. Moreover, NEHEN had gone farther than HIPAA, capturing additional efficiencies by cutting out billing middlemen and clearinghouses. And in doing so, the network demonstrated that businesses in the health care industry gain value in going above and beyond federal law when it comes to administrative efficiency.

Table 1. Savings from NEHEN participation, large physicians' group (>200 physicians)³⁰

	Year 1	Year 2	Year 3
Labor savings:	\$397,975	\$ 397,975	\$ 397,975
+ Improved collections:	\$88,010	\$88,010	\$88,010
Gross savings:	\$485,985	\$485,985	\$485,985
- NEHEN program mgmt. fees:	\$72,000	\$72,000	\$72,000
- Implementation costs (H/W, network, labor):	\$250,000	\$10,000	\$10,000
Net savings (cumulative):	\$163,985	\$568,905	\$972,890

Profile in Efficiency: New England Healthcare EDI Network (NEHEN)

System: Standardized HIPAA transactions, such as claims and eligibility inquiries transmitted via secure computerized network

Governance: Operated as a non-profit, small full-time staff, stakeholder board of managers

Funding: Stakeholder fees

Population served: more than 2.5 million residents

Results:

- Networks 46 hospitals, 5,000 physicians, 6 health plans (and 1 local insurer), and 8 national insurers through local affiliates.
- Saves health care payers and providers millions of dollars annually

Key to Success:

- Member investment through open governance, financial investment, business value-added
- Non-regulatory role
- Secure network
- Services varied according to member needs and capabilities

Administrative Efficiency: Making it Happen in California

Health care insurers and providers can cut costs and benefit patients by streamlining and standardizing administrative procedures. But most in California have been slow to do so, for several reasons.

First, in a large state such as California, there are dozens of insurers and thousands of health care providers who would need to be brought into a streamlined system in order to maximize its benefits. Moreover, despite some collaboration, health insurers are competitors, and have often spent a great deal of energy and money in devising administrative systems that serve their needs. These expenditures represent “sunk costs,” making insurers reluctant to switch to a new system. In addition, smaller organizations such as individual practices or community clinics may feel they lack resources to invest in information technology, which could deter them from participating.

However, the examples of UHIN and NEHEN provide powerful counterpoints to these concerns. NEHEN, for example, rapidly built near-consensus around its model in the regional health care industry by winning support of several major players,

creating a center of gravity around the plan. In both the UHIN and NEHEN cases, a large number of competitors were united under one tent by the reality of efficiencies so significant that big, established organizations were able to net savings, even after paying upfront to revamp their old systems—and by the fact that these savings did not grant competitive advantage to any one player. Smaller organizations also joined the networks in large number, aided by technology assistance and, as in the NEHEN case, flexible and lower-cost access to the network.

The barriers to creating a similar network that some California health care payers and providers may perceive, in other words, are surmountable.

Additionally, the time is ripe for California to take action. In both Utah and New England, new systems were sparked by payers’ and providers’ need to comply with new legislation, and today California faces a similar—if fleeting—window of opportunity, the result of key health care reforms at the federal and international levels.

The federal American Recovery and Reinvestment Act of 2009 (ARRA), for example, includes a series of health care

provisions. Some of these provisions provide massive funding for updating our health care system, such as upgrades to electronic medical records. Other provisions intended to protect patient privacy extend the HIPAA privacy requirements from electronic data only to *all* medical records, including paper records. Because it will be difficult to meet the law's requirements and continue to use paper records, the ARRA essentially pushes the health care industry toward an all-electronic data system.³¹ A network to improve administrative efficiency will also help California meet the ARRA electronic records requirements.

The American health care industry is also facing a 2013 deadline for updating the codes it uses to classify and communicate

about diseases. These codes, established by the World Health Organization, provide a common international language for symptoms, diseases, diagnoses, and treatments, and are updated periodically. They are used in many aspects of health care, from clinical use to insurance claims and contracts. The United States has been slow to implement the latest codes, ICD-10, which are already in use in many places around the world—in part because ICD-10 uses a substantially different classification logic than its precursor, ICD-9. But with the 2013 deadline approaching, the process of updating to a new system could be made much easier (and possibly less expensive) for California's health care industry with a streamlined, electronic system for health care billing and claims processing.

Policy Recommendations

As the health information networks in Utah and New England demonstrate, there are many available solutions for increasing administrative efficiency in the health care system. To improve the statewide health care system, California should find ways to encourage its many, diverse health care stakeholders to unite around a common effort to streamline health care administration. The state can accomplish this goal by:

- **Actively encouraging the formation of a health information network similar to the Utah and New England examples.** The state should convene public and private health care stakeholders in a partnership designed to help members reap the rewards of administrative efficiency without granting any one member competitive advantage over the others. The network should further be structured so that it can be integrated into any statewide system for the sharing of electronic medical records.
- **Providing short-term, low-interest and need-based loans to support**

participation in the network. Most healthy businesses will be able to make the small investments necessary to collectively jump-start a California health information network that will net them significant savings. However, the state could additionally offer short-term, low-interest loans on an as-needed basis to organizations which could prove that the network membership fee would represent a hardship and negatively impact their business.

A new health information network will also work hand-in-hand with other policies to fix health care in California. Requiring health insurers to spend a minimum percentage of premium revenues on health care, for example, would encourage improved efficiency in overhead spending, which can be achieved through participating in an information network. The network could also operate in tandem with new electronic health records systems and health information exchange networks, both of which will grow in future years as a result of increased federal funding. California should ensure that any electronic health exchange network developed in

the state does not preclude the creation of a system to improve administrative efficiency. Ideally, the state would use a new

health information network as a catalyst to update and reform administrative systems as well.

Conclusion

Increasing administrative efficiency by developing a health information network with standardized billing and credentialing forms is an important step toward fixing health care in California—but it is not the only step. The time is ripe for change, and California should act quickly to enact

comprehensive health care reforms, of which a health information network should form an integral and cost-saving part. Creating such a network will give Californians a health care system that is more responsive, more affordable, and more efficient.

Notes

1 According to the study, “32 percent have skipped dental care, 21 percent... haven’t filled a prescription and 20 percent...have skipped a recommended medical test or treatment.” National Public Radio, Kaiser Family Foundation and Harvard School of Public Health, *The Public and the Health Care Delivery System*, April 2009, 5. Available at www.kff.org/kaiserpolls/upload/7887.pdf.

2 Elizabeth Ridlington and Mike Russo, CALPIRG Education Fund, *Diagnosing the High Cost of Health Care: How Spending on Unnecessary Treatments, Administrative Waste, and Overpriced Drugs Inflates the Cost of Health Care in California*, June 2008.

3 Mean annual wage in California was \$37,321 in 2001 and \$40,977 in 2004; The 2001 wage adjusted for 2004 inflation is equal to \$39,583. Real wage increase was 3.5 percent between 2001 and 2004. Mean annual wages from State of California, Employment Development Department, *OES Employment and Wages by Occupation, State of California, 2003 3rd Quarter and 2004 1st Quarter*, December

2001 and June 2004. Inflation rate from U.S. Bureau of Labor Statistics, *CPI Inflation Calculator*, available at www.bls.gov/data/inflation_calculator.htm.

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6 Ibid.

7 See note 2.

8 See note 5.

9 Utah State Code R590-164

10 Jan Root, Utah Health Information Network, *Utah Health Information Network: A Community-Based HIPAA Implementation* [PowerPoint

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12 HTP, Inc., *Customer Success Story: Utah Health Information Network (UHIN)* [fact sheet], 3 February 2006. Available at www.htp-inc.com/files/2.3.06_UHIN.pdf; HTP, Inc., *HTP Co-founder to Present RHIO Funding Case Study at 12th National HIPAA Summit* [press release], 21 March 2008. Available at www.1888pressrelease.com/htp-co-founder-to-present-rhio-funding-case-study-at-12th-na-pr-o2zb545a3.html.

13 Jan Root, Executive Director, Utah Health Information Network, personal communication, 6 May 2009.

14 Annual transactions: See note 11. Average cost: See note 13.

15 See note 13.

16 California clearinghouse transaction costs are not directly comparable to costs per transaction at UHIN or NEHEN since clearinghouses typically “clean” data, filtering it to make sure that the data presented seems reasonable, and UHIN and NEHEN do not. (For example, a clearinghouse would verify that a given subscriber number actually exists with a given insurer. UHIN and NEHEN do not look at the content of the data they deliver, acting exclusively as delivery conduits.) However, better technology could help clean up the data on the front end, eliminating the need to filter it later. Though published statistics are difficult to find, a survey of clearinghouse websites indicates that many charge on the order of 25-35 cents

per transaction, and some charge up to double that amount.

17 The average health insurance claim is processed in 7 days in Utah, compared to a national average of 45 days. HTP, Inc., *HTP Co-founder to Present RHIO Funding Case Study at 12th National HIPAA Summit* [press release], 21 March 2008. Available at www.1888pressrelease.com/htp-co-founder-to-present-rhio-funding-case-study-at-12th-na-pr-o2zb545a3.html.

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20 U.S. Department of Health and Human Services, *HIPAA Administrative Simplification Statute & Rules* [fact sheet], downloaded from www.hhs.gov/ocr/privacy/hipaa/administrative/index.html on 22 June 2009.

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