MARYLAND HEALTH CARE COMMISSION

SPOTLIGHT ON MARYLAND EDI

2004 EDI Progress Report

Published December 2004

The Maryland Health Care Commission (MHCC or Commission) has a mandate to promote electronic data interchange (EDI) in Maryland and does so through its provider educational initiatives, data collection activities, and Electronic Health Network (EHN) certification program. COMAR 10.25.09 requires payers in Maryland to contract only with MHCC-certified EHNs for transmission of electronic health care transactions.[1] Payers must report health care transaction volumes to the Commission through submission of an annual EDI Progress Report. MHCC uses information reported each year on the EDI Progress Report to measure the progress of EDI in the state, gauge the success of current EDI initiatives, and identify areas for new initiatives.

The 2004 EDI Progress Report focuses on practitioner and hospital EDI claim shares and includes health care transactions reported during the 2003 calendar year by government (Medicare and Medicaid) and private payers. The Commission is planning to release an EDI Dental Spotlight during the first quarter of 2005. For the most part, dental EDI accounts for only a small portion of most payer's electronic claims share.

The implementation of standard health care transactions on October 16, 2003 under the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) defined standards for electronic claims and other health care transactions. HIPAA's standard transaction regulations require payers to accept transactions such as eligibility in a health plan, enrollment/disenrollment in a health plan, health care payment and remittance advice, health claim status, referral certification and authorization, and health plan premium payments in a consistent format.[2] In this year's report, the Commission included summary information on non-claim health care transactions.

Medicare, Medicaid, and thirty-six private payers submitted an EDI Progress Report that was included in this year's analysis. Health care transactions included in this report reflect both insured and self-funded employer groups. The report's primary focus is on the EDI claim performance of government versus private payers, six large private payers, and the other private payers. Payers that make up the six large private payers are Aetna, CareFirst, Cigna, Kaiser, MAMSI, United Health Care, and their affiliated companies. Although MAMSI and United Health Care merged in 2004, they reported data separately during this reporting period (see Reporting Payers list at end of report).

EDI IN 2003

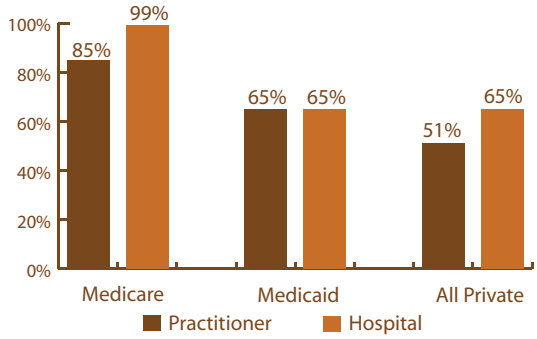
Government and Private Payer EDI

Technology adoption and market competition spurred EDI growth statewide. All combined, government and private payer practitioner and hospital EDI share in 2003 was about 63 percent, an increase of nearly 2 percent from the prior year. Private payers reported a combined practitioner and hospital EDI share of roughly 53 percent, an increase of about 5 percent from last year.

HIPAA transaction standards went into effect before most covered entities could fully implement the requirements.[3] Most private payers used the HIPAA implementation requirements as an opportunity to update their information systems which included expanding EDI programs.

The Centers for Medicare and Medicaid Services (CMS) EDI shares are considered the bench mark against which other payers are judged. CMS did not report significant growth, although no private payer has come close to approaching Medicare's EDI shares. CMS promotes EDI adoption by offering providers no-cost software that directly interfaces to Medicare systems. As shown in Figure 1, CMS led the group in both practitioner and hospital EDI share in 2003.

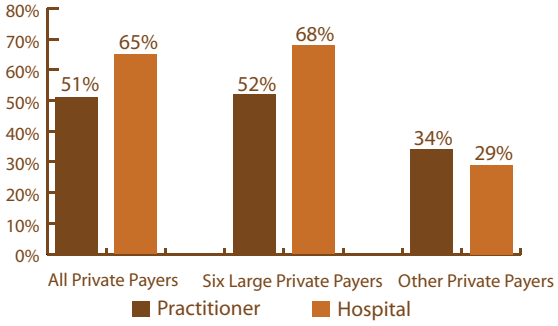
Fig 1. 2003 Practitioner and Hospital EDI Share Government and Private Payers



Private Payer EDI

Six large private payers drive EDI adoption rates among providers in Maryland and their EDI share exceed that of the thirty other private payers. The six large private payers accounted for nearly 94 percent of the practitioner and hospital claim volumes reported. Among the thirty other private payers, four did not report any practitioner or hospital EDI. The six large private payers reported a combined practitioner and hospital EDI share of approximately 54 percent, as compared to about 33 percent reported by the other private payers. Hospital EDI share of the six large private payers was greater than practitioner EDI share; conversely the other private payers reported a higher practitioner EDI share as compared to hospital. Variations in technology and claim submission requirements between the six large private payers and the other private payers account for the differences in EDI share as shown in Figure 2.

Fig 2. 2003 Practitioner and Hospital Private Payer EDI Share

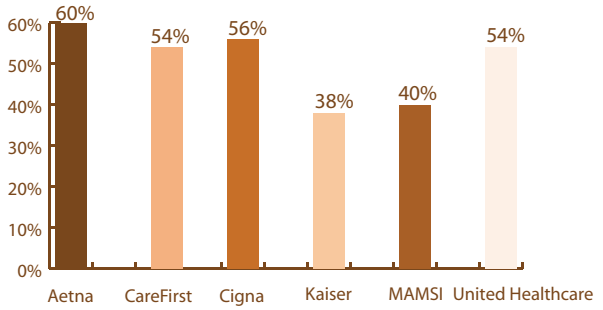


In general, the EDI programs of the six large private payers encourage providers to submit claims electronically. Effective programs include offering multiple EHNs for direct claim submission, expanding Internet claim submission and tracking services, and targeting outreach and educational programs to providers. Offering select providers limited economic incentives to submit claims electronically have also been reported.[4]

The Six Large Private Payers

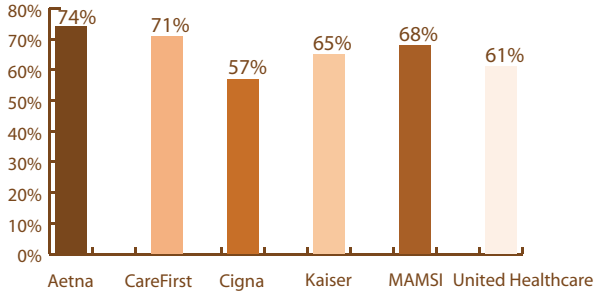
Sound EDI expansion programs produce fairly consistent gains in electronic claims share for nearly all of the six large private payers. As shown in Figure 3, only Kaiser and MAMSI reported a practitioner electronic claims share below 50 percent, roughly 20 percentage points less than Aetna's practitioner electronic claims share.

Fig 3. 2003 Practitioner EDI Share, Six Large Private Payers



Limited claim attachment requirements among the six large private payers produce positive results in hospital EDI shares, as seen in Figure 4. Nearly all large private payers enable hospitals to submit most claims without any hard copy attachments. In most instances, hospitals pre-approve admissions with the payer and submit any required documentation in advance of the claim. As seen in Figure 4, with the exception of Cigna, all large private payers reported their hospital EDI share in excess of 60 percent.

Fig 4. 2003 Hospital EDI Share, Six Large Private Payers



PRIVATE PAYER EDI TRENDS, 2001–2003

Electronic Claim Shares

Market opportunities produced steady growth in practitioner and hospital EDI shares in Maryland over the last three years. Competition among EHNs, improvements in practice management and hospital-based systems, and the expansion of internet capabilities contributed to EDI growth among providers.

Expectations that HIPAA transaction standards would have a negative impact on EDI were not realized, and in fact, may have spurred growth as both payers and providers were generally paying more attention to electronic transactions. Prior to HIPAA, private payers could choose not to implement any EDI programs. The requirements set forth by HIPAA require payers to accept electronic claims from all providers that choose to submit electronically.

Figure 5 shows the growth of practitioner EDI share vs. hospital EDI share from 2001 through 2003. Hospital EDI share showed a consistent rate of growth of about 6 percent yearly. Practitioner EDI share grew more slowly between 2001 and 2002, but increased roughly 5 percent between 2002 and 2003. This increase is generally attributed to several payer EDI expansion initiatives in 2003 that targeted high volume paper submitters and expanded EDI education programs.[5]

Fig 5. Private Payer Practitioner and Hospital EDI Share, 2001-2003

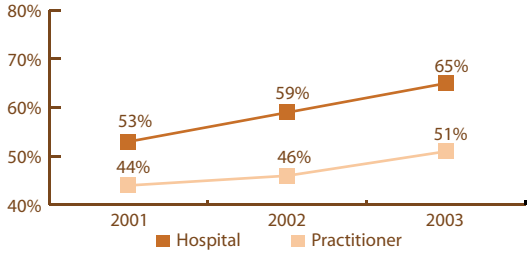


Figure 6 illustrates that although the other private payers have a smaller overall EDI share, they had a greater rate of increase in practitioner EDI share as compared to the six large private payers, narrowing the gap between them. On the other hand, Figure 7 shows that hospital EDI share of the six large private payers grew at a faster rate than that of the other private payers. The larger market share of these large payers encourages provider participation in EDI, an advantage the other private payers with smaller market share do not have. Some of the other private payers were also slower to implement EDI programs prior to the implementation of HIPAA transactions.

Fig 6. Private Payer Practitioner EDI Share, 2001-2003

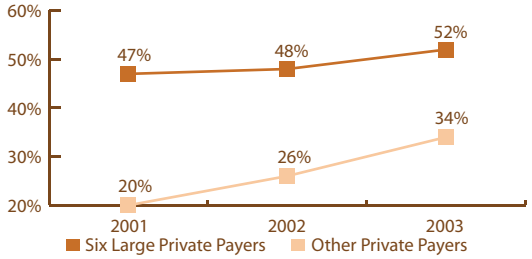
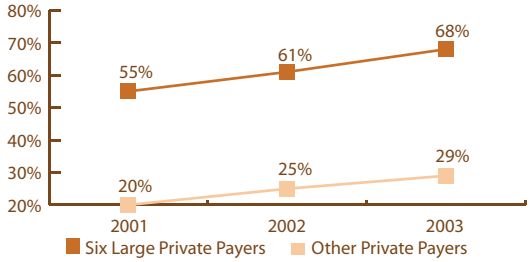


Fig 7. Private Payer Hospital EDI Share, 2001-2003



Auto Adjudication of Practitioner and Hospital Claims

Improvements in payer EDI systems boost auto adjudication rates among private payers. An auto adjudicated claim is one that is submitted electronically, enters a payer's claim adjudication system, and receives some sort of payment or denial without requiring manual intervention by a claim processor. Auto adjudication reduces a payer's administrative overhead and reduces the amount of time it takes a payer to process a claim.

Auto adjudication rates are higher for non-HMOs than for HMOs. Typically, HMO claims are subject to more review by payers, often due to authorization and/or attachment requirements. Figure 8 shows that practitioner auto adjudication rates increased for both HMO and non-HMOs. The consistent increase among the HMOs is reflective of payer initiatives to maximize auto adjudication by reducing the number of claim edits, required attachments, and referral requirements. Figure 9 shows that while non-HMO hospital auto adjudication rates exceeded the HMO rate, they declined slightly in 2003. This is largely attributed to a decrease in CareFirst's auto adjudication of their non-HMO claims.[6]

Fig 8. HMO and Non-HMO Practitioner Auto Adjudication, Six Large Private Payers, 2001-2003

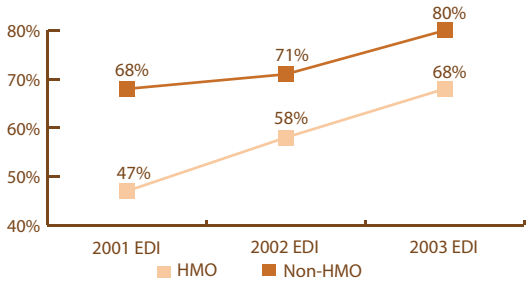
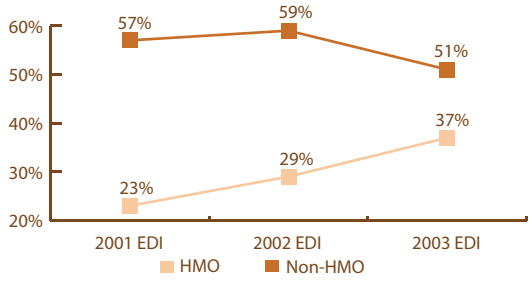


Fig 9. HMO and Non-HMO Hospital Auto Adjudication, Six Large Private Payers, 2001-2003



MHCC-CERTIFICATION PROGRAM

Private Payer Electronic Health Network Designations

EHNAC[7] accreditation and MHCC-certification improve business processes for EHNs operating in Maryland. Presently, payers can choose from fifteen MHCC-Certified EHNs doing business in the state. Increased competition among the networks continues to raise service levels and lower payer and provider usage costs. Over the last five years, Maryland attracted 11 new EHNs to the marketplace. Table 2 lists EHNs doing business in the state and the number of payer designations. Variation in EHN designation exists among the six large private payers. Four of the six large private payers have increased the number of contracted EHNs over the last year, and others have plans to do so in the future. Multiple contracts and pathways enable more providers to submit claims directly to payers and avoid network redirect charges. Table 3 shows the number of networks designated by each of the six large private payers.

Table 2. Electronic Health Networks Designated By Private Payers in 2003

Electronic Health Network	Number of Payers Designating EHN
WebMD Envoy	29
Proxymed	15
NDCHealth	7
McKessonHBOC	6
Per Se Technologies	6
Electronic Network Systems (ENS)	4
Health Data Management (HDM)	4
Payerpath	2
GHN-Online	1
Health Data Exchange (HDX)	1
Mutual of Omaha's Medicare Crossover Clearinghouse	1
The SSI Group	1
Specialty Electronic Health Network	
Affiliated Network Services (ANS) - Dental	5
Eyefinity - Vision	1
Practiceworks - Dental	1

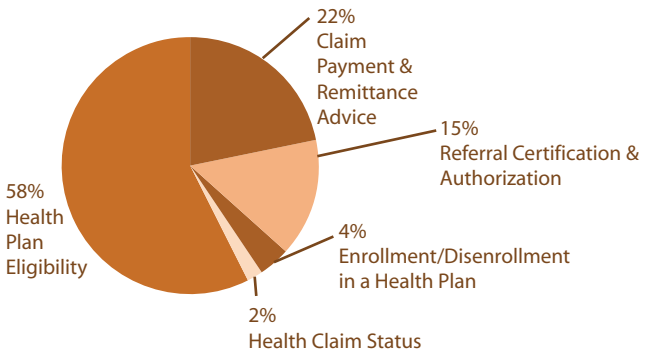
Table 3. Number of Electronic Health Networks (EHNs) Designated by the Six Large Private Payers in 2003

Payer	Number of Designated EHNs
MAMSI	7
Aetna Healthcare	5
United Healthcare	4
Cigna	2
CareFirst	1
Kaiser	1

Non-Claim HIPAA Transactions

EDI activity gains momentum for non-claim transactions in Maryland. HIPAA requires payers to offer providers the ability to conduct a number of transactions electronically. Payers were asked to report volumes of non-claim HIPAA transactions for the first time this year. These non-claim transaction standards were intended to enable providers to replace many of the arduous tasks associated with the daily activities of a billing office. Figure 10 illustrates the share of each non-claim HIPAA transaction reported by private payers. Maryland payers also reflect a national trend of expansion of payer website offerings of non-claim HIPAA transactions and other functionality targeting providers, members, employers and insurance brokers.[8]

Fig 10. Non-Claim HIPAA Transactions



MHCC - A VALUE ADDED RESOURCE

MHCC's EDI programs are expected to increase EDI activity over the next year. The Commission's role in EDI continues to spur growth among payers and providers. The Commission has an ambitious EDI/HIPAA schedule for the upcoming year. Several statewide regional provider conferences are planned to discuss EDI adoption. Emphasis will be placed on increasing adoption of electronic claims and several other of the non-claim transactions. MHCC plans to use these conferences as a way to introduce providers to the use of new technology designed to expand EDI use.

The Commission plans to continue working with payers on their EDI adoption strategies. The EDI/HIPAA Workgroup (workgroup) is in its fifth year and continues to bring stakeholders together to advance EDI and HIPAA adoption. More than 70 representatives, consisting of payers, providers, EHNs, software vendors, and consultants, participate in the workgroup. Leading accomplishments of the workgroup last year included: The Practice Management Software Self-Survey Evaluation Tool, Payer Internet Guide, and The HIPAA Security Readiness Assessment Guide. The activities of the workgroup continue to gain recognition among payers, providers, and EHNs.

The Commission is frequently called upon to present on the federal HIPAA regulations. A number of regional Medical Group Management Associations and allied health associations invited MHCC to overview the HIPAA requirements at their annual conference. The Commission routinely receives more than 15 industry requests each month for consultative services on the HIPAA regulations. HIPAA offers the potential to generate a number of efficiencies for practitioners and health care facilities related to billing activities.

MHCC plans to continue expanding market competition through its network certification program. The Commission's network certification program continues to attract EHNs to Maryland. Commission staff has identified electronic prescribing as a growing area that falls under its EDI mandate. MHCC plans to implement EHNAC's electronic prescribing accreditation program to certify electronic prescribing networks. This certification program is projected to bring at least three new vendors to the market in the first year.

The Commission expects to continue providing consultative support to the Maryland/D.C. Collaborative. This is an effort on the part of many hospitals and some physician groups to establish inter-organizational capabilities to exchange clinical information. The Maryland/D.C. Collaborative has evolved from a vision shared by a group of community physicians in 1999 to a regional coalition consisting of physicians, hospitals, and academic health systems aiming to implement an electronic medical record (EMR). The implementation of EMR will increase EDI activity statewide through the sharing of clinical information. Over the last year, the Maryland/D.C. Collaborative has successfully broadened its membership and received some grant funding from the federal Health Resources Services Administration (HRSA). The collaborative intends to seek commercial vendors to respond to the technical specification in the first quarter of 2005.

Endnotes

[1]Health General §4-302 mandates that payers doing business in Maryland use only an MHCC-Certified EHN.
[2]Department of Health and Human Services, Office of the Secretary, Health Care Financing Administration, 45 CFR Parts 160 and 162, Standard for Electronic Transactions.
[3] 107th Congress 1st Session, H.R.3323.
[4] Aetna is an example of a large payer that offers primary care physicians incentives to submit claims electronically.
[5]Information reported to staff by Aetna, Cigna, and CareFirst.
[6]MHCC's multiple requests for information from CareFirst were not responded to by this payer.
[7]Electronic Health Network Accreditation Commission
[8]"How Health Plans Are Using The Internet to Reach Customers, A Survey of Payer Websites," Capgemini, November 2004.

Reporting Payers

Top Private Payers:
Aetna: Aetna Health, Inc., Aetna Life Insurance Company; **CareFirst:** CareFirst BlueChoice, Inc., CareFirst of Maryland, Inc., Delmarva Health Plan, Inc., Free State Health Plan, Inc.; **Cigna; Kaiser; MAMSI:** MAMSI Life and Health Ins Co., MD-Individual Practice Association, Inc., Optimum Choice, Inc.; **United Healthcare:** United Healthcare Insurance Co., United Healthcare of the Mid-Atlantic, Inc.

Other Private Payers:
Allianz Life Ins. Co. of North America, American Republic Insurance Co., Ameritas Life Insurance Corp., Coventry Health Care of Delaware Inc, DentaQuest Mid-Atlantic, Inc., Educators Mutual Life Insurance Co., Fidelity Insurance Company, Fortis Insurance Co., GE Group Administrators, Golden Rule Insurance Co., Graphic Arts Benefit Corp, Great-West Life & Annuity Ins. Co., Group Dental Service of Maryland, Guardian Life Insurance Co., Mega Life & Health Ins. Co., Metropolitan Life Insurance Co, Mid-Atlantic Vision Services Plan, Inc., Nationwide Life Insurance Co, New England Life Insurance Co., New York Life Insurance Co., PHN-HMO, Inc., Principal Mutual Life Ins. Co., Reliastar Life Insurance Co., State Farm Mutual Automobile Ins. Co., Transamerica Life Insurance Co., Trustmark Insurance Co., Unicare Life & Health Insurance Co., Union Labor Life Insurance Co., United Concordia Companies, Inc., United Wisconsin Life Ins. Co.

SPOTLIGHT ON MARYLAND is published by MHCC, EDI Programs and Payer Information Systems.

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