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Health claims administration in Canada

Content

Executive summary

Health claims are statements of services and costs from a healthcare provider or facility submitted for payment or reimbursement to an insurance or coverage provider.

Governments are re-designing traditional service delivery models to drive greater value across health systems in the face of increasing economic pressures. Driven by evolving government policies, growing administration complexities and increasing requirements of underlying technologies, health claims administration is undergoing a major transformation across Canada and around the world.

To improve patient outcomes while reducing system utilization and costs, governments are increasingly pursuing new payment models. Acting on recommendations such as those found in the 2012 Commission on the Reform of Ontario's Public Services – "Public Services for Ontarians: A Path to Sustainability and Excellence" – governments are looking to reduce the proportion of Fee-for-Service (FFS) funding models relative to capitation and blended salary funding models for physicians (Figure 1).[1] These changes are aimed at improving patient outcomes, especially for patients requiring proactive treatment and monitoring of chronic conditions such as diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disorder (COPD). Remuneration policies that align physician financial incentives with holistic monitoring of patients should increase quality of care, reduce future demand for acute and episodic care and reduce overall system costs.

This transformation is fundamentally altering the way health services are delivered and the way physicians, pharmacists and other providers are being compensated for their services through healthcare payment systems. As governments redesign both compensation structures and the scope of services provided by healthcare practitioners, underlying claims solutions technologies must become more flexible and integrated. Additionally, similar policy changes across dental and workers' compensation claims are increasing overall claims volume and complexity, leading to increased need – and raised expectations – around the value and efficiencies that data analytics can potentially deliver.

Figure 1 – Trends in the Canadian health claims landscape

Medical Claims

Physicians' compensation is migrating away from a long-standing fee-for-service compensation structure as provincial governments move towards pay-for-performance models in efforts to increase patient service levels and promote initiatives such as chronic disease management and interdisciplinary care.

Drug Claims

To decrease overall health system costs and improve patient care, pharmacists are being asked to provide a wider array of services to patients, which is changing the channels and services for which they are compensated.

Workers Claims

Workers Compensation boards are gradually moving towards an early "return-to-work" philosophy, which introduces the need for increased tracing and analytical capabilities to assess patients' progress through the system.

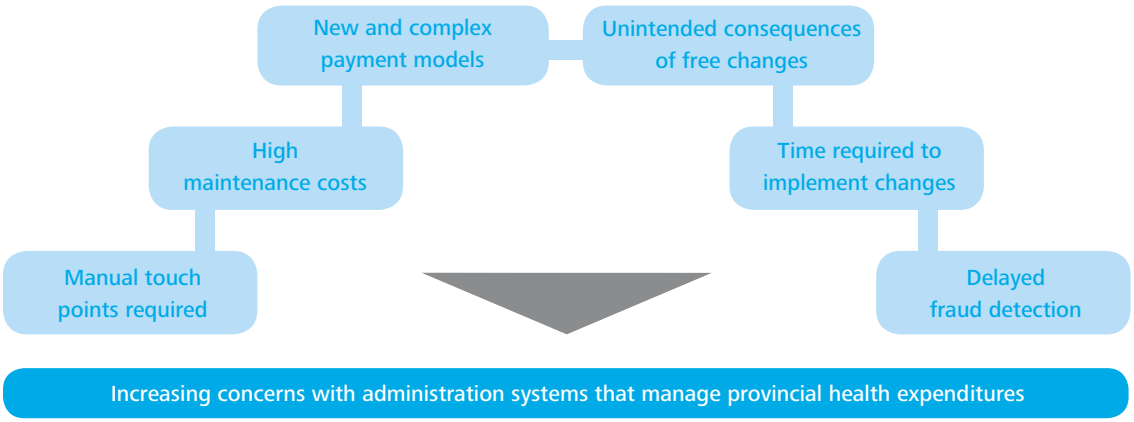
Demands on claims processing systems have grown considerably, with patient/client co-pays, deductibles, balance billing and self-pay options increasing systems availability requirements related to electronic fund transfers (EFTs) and/or online capabilities. The majority of current Canadian health claims solutions have been in place for more than 20 years and, while stable and reliable in processing claims over their lifetime, they are now unable to meet these growing demands (Figure 2). A major transformation is required to keep up with the rate of change; however, upgrade requirements are often cost prohibitive, leading to manual and unsustainable workarounds. Beyond cost, these legacy systems often lack the flexibility and adaptability required to accommodate updates and reforms to underlying policies. Without significant capital investment for transformation initiatives, these systems will continue to require increased manual touch points, driving processing costs higher.

At the same time, governments are striving to be more strategic in the services they operate directly and are looking more and more towards private sector partners to deliver core competencies. Private sector partners can provide access to world-class administration solutions with increased functionality around on-time payments, advanced fraud and awareness detection, streamlined audit functions and other data analytics capabilities applicable to claims processing. These applications provide the requisite functionality and adaptability to deliver real value and allow for future system changes at a minimal cost.

In a time of government restraint and austerity, decreasing capital investment is a budget imperative. Partnerships and alternative service delivery models can help accomplish this, reducing the costs of application upgrades and replacement. While infrastructure projects (e.g., hospitals and roads) have historically been the domain of such alternative models, governments are now looking for support with service delivery as well. Beyond immediate capital benefits, governments are also recognizing opportunities to create greater system value through non-traditional or outsourced service delivery partnerships. The health claims industry can not only lower costs but also meet capability and capacity demands more effectively by leveraging valuable external skills, expertise and resources.

Health claims today are paid in vastly different ways than in the past. In order for governments to derive full system value from their transformative policies, new service delivery models for claims administration need to be considered. Across jurisdictions, it is crucial that health claims systems consider the evolving needs of the health care industry and develop a plan for delivering flexible, reliable and on-time health claims application processing. To enable this, governments should identify potential partners and explore alternative service delivery models that can provide not only relief from significant capital expenditures but also valuable access to industry expertise. These transformations are not a panacea, but part of an overall solution for improving healthcare quality and increasing system efficiencies.

Figure 2 – Challenges with existing legacy systems



Current state of health claims systems

Transformation is imminent

Across Canada, health claims administration systems in the public sector are undergoing or about to undergo major transformation. The administration systems currently in use for medical, drug and workers' compensation board claims do not meet current and future government needs. The scope of these services has widened, as have compensation structures, requiring out-of-date claims systems to be transformed into or replaced by modern systems that offer increased flexibility and improved analytical capabilities. Identifying future claims administration needs will be critical for developing these systems and allying with appropriate private partners.

The administration systems currently in use for medical, drug and workers' compensation board claims do not meet current and future government needs.

Table 1 – Compensation models used across Canada

Compensation model	Description and key implications	Jurisdiction usage
Fee-for-service	• Fee-for-service is the traditional system of reimbursement • Healthcare providers bill the jurisdiction for services supplied according to a pre-determined list of billing codes set by negotiation among the jurisdiction, the medical association, and, increasingly, regional health authorities	AB, BC, MB, NB, NL, NS, ON, PE, QC, SK, YT
Capitation	• Capitation is a prospective payment of a fixed amount for each person that is meant to relate to the anticipated medical expenditure for that type of patient in a given time period • It is generally accepted that this form of reimbursement needs to be risk adjusted to ensure complex care patients receive equal access. Capitation formulae often adjust for age, sex, illness and other factors. Capitation requires a form of voluntary or mandatory patient rostering to track which provider is responsible for which patients	AB, MB, ON, SK
Contractual	A pre-negotiated amount (often annual) is determined for a set volume of services. Often specific service volumes are not specified, but expectations are set regarding hours, days, and weeks of service	AB, BC, MB, NB, NL, NT, NU, NS, ON, PE, SK, YT
Salary	Physicians are employed on a salaried basis	AB, MB, NB, NL, NT, ON, PE, QC, SK
Sessional	Physicians are paid on an hourly or daily basis; this model is traditionally used in hospital emergency rooms	AB, BC, MB, NB, NL, NT, NS, ON, PE, QC, SK, YT
Block	Block funding is provided to a group of physicians	AB, NL, NS, ON, QC
Blended	The above models are blended with free for service	BC, MB, PE, QC, SK, AB

Medical claims processing

As governed by the Canada Health Act, physicians are largely compensated through medical insurance plans that are administered provincially and funded via the taxpayer. Historically, these plans have covered similar services and most often remunerated physicians through a fee-for-service (FFS) model. In recent years, however, each province has begun a process of modernization in terms of what they pay for (e.g., which services) and how they pay for it (e.g., salaries, bonuses, health-outcome based payments). Seeking to drive greater value in the system, capitation and pay-for-performance are replacing FFS as the primary remuneration model, aiming to influence physician behaviour and incent a population-based approach rather than an individual-based approach to patient care (Table 1).[2]

Between 1999 and 2010, payments to physicians in Canada almost doubled while the portion related to fee-for-service payments declined (Figure 3). This points to an evolution in physician payment models and highlights an opportunity to transform the entire health claims administration system.[3, 4]

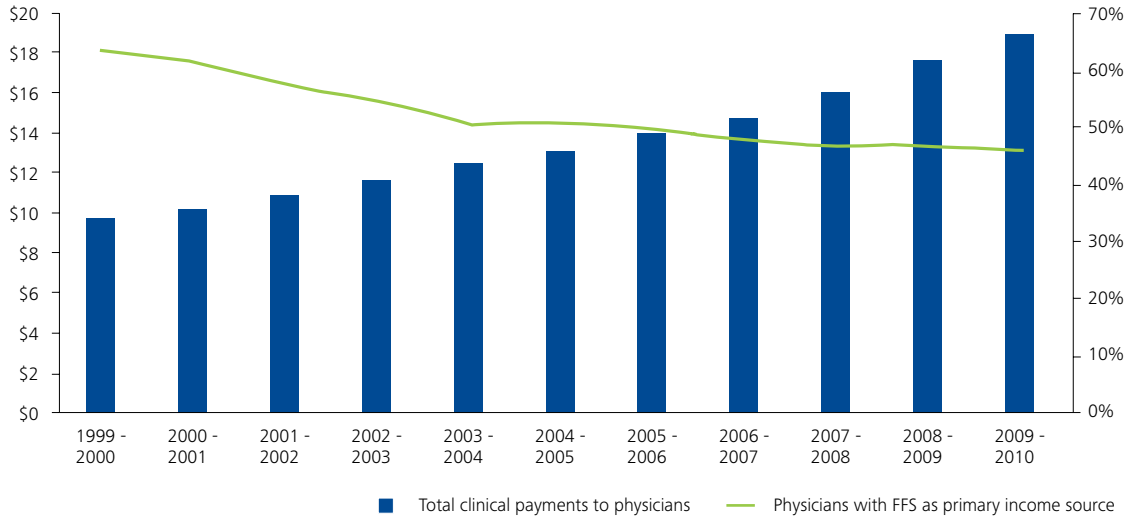
Policy changes affecting medical claims

With traditional physician payments now growing faster than the gross domestic product (GDP), jurisdictions are attempting to incent and reward not only volume but also clinical process improvements and outcomes. Jurisdictions are requiring both institutional and individual providers to demonstrate adherence to "best" clinical practices and in some cases to improving patient outcomes. As a result, traditional payment models such as FFS, whose only dimension is volume, are becoming obsolete.

Challenges faced by the current medical claims system

Current claims processes are labour intensive, highly transactional and involve significant payment error and fraud risks. Moreover, they provide limited management information and insight and do not support policy analysis and scenario planning. Due to the policy changes and social imperatives outlined in the previous section, multiple physician compensation models have been or are being developed across the country. As a result, claims processing systems can't keep up, and complexity has become an increasing administrative and IT burden.

Figure 3 – Canadian Physician Remuneration Models (1999-2010) ($M)



All Canadian medical claims processing platforms were originally built to process only the FFS model. Over time, some additional capabilities have been added to process hourly types of arrangements; however, almost all jurisdictions are now struggling to enable the new remuneration models in their legacy systems. Key challenges include:

- Difficulty in understanding the physician's complete compensation, as information must be pulled from multiple sources
- Lack of integration and technology capabilities making linkages to health outcomes and individual health measures difficult
- Difficulty in understanding which elements of the models affect health outcomes
- Expensive and time-consuming workarounds required to accommodate transition from FFS compensation models, e.g. shadow billing

As a result, there is currently both the impetus and opportunity to transform medical claims processing capabilities to enhance efficiency, accuracy and service levels for physicians, patients and governments.

Drugs claims processing

Historically, pharmacists have operated under a compensation structure similar to physicians' FFS model, dispensing medication then billing the provincial government the appropriate fees. However, as healthcare system costs have increased, the role of pharmacists has evolved to provide enhanced patient services. With pharmacists now delivering care and monitoring services to patients in the community, their role has evolved to become the front line of care. Pharmacists provide counselling and advice on routine cases, often catch errors in prescriptions and refer patients back to doctors' offices as necessary.[5] This enhanced role has come with policy changes that seek to incent such lower cost, value-added services, resulting in still more pressure on outmoded claims administration systems.

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Policy changes affecting drug claims

Compensation structures have changed to reflect the growing cost of patients seeking primary, secondary and tertiary care from physicians and hospitals. By shifting an increasing number of services towards lower cost providers, such as pharmacists, governments expect savings from reduced hospital and physician expenses. Services being shifted include consultative services and simple medical procedures, and pharmacists are increasingly expected to interpret prescriptions.

Challenges faced by the current drug claims system

The evolving role of pharmacists in the health claims ecosystem has created a need to modify the existing claims systems. Current systems that allow pharmacists to bill for prescription filling services are being adapted to handle compensation claims for increased levels of consultative and professional services, a process that can be time-consuming and expensive for governments.

In the future, drug claims systems will also need to have increased integration with the broader health system and provide a more comprehensive picture of patients' health needs. This integration will give pharmacists and physicians more information to make better treatment decisions, while governments will be able to better manage costs.

Workers' Compensation Board claims processing

Policy changes affecting workers' compensation claims

Workers' compensation boards face the unique challenge of decreasing claims costs in a time when the workforce is aging. For every ten-year increase in average worker age, the risk of costly loss-of-earnings benefits increases by 16%. To address this, workers' compensation boards can either raise employer premiums, go into deficit or design alternative strategies to get workers back on the job. In the current economy, it would be difficult for employers to afford higher premiums, and in provinces like Ontario, the Workplace Safety and Insurance Board (WSIB) is already running a high deficit or "funding gap" that they are actively trying to decrease.[6] As a result, back-to-work strategies are gaining prominence (Table 2).

Challenges faced by the current workers' compensation claims system

With the increasing use of return-to-work programs, workers' compensation boards require a more comprehensive and holistic view of their organizations. This requires a claims system that integrates with boards' patient tracking software and accounting systems to provide full visibility into any savings return-to-work programs are generating. To identify even more cost-savings, boards may consider investing in customer analytics that are not available in current systems. Customer analytics can provide valuable insight into the stages of worker recovery, allowing caseworkers to get them back on the job faster. Customer analytics would also allow workers' compensation boards to develop best practices for recovery and identify a range of cost-savings opportunities.

Unfortunately, current workers' compensation board claims systems are largely out-of-date and cannot be updated with return-to-work capabilities and customer analytics at a reasonable cost. As contracts for claim systems are renewed, adding these capabilities can help reduce deficits and lower expenses, even as the workforce continues to age.

Table 2 – Health claims policy changes implemented by worker compensation boards

Compensation model	Description and key implications	Jurisdiction usage
Medical claims	Chronic disease management	Increased rates of chronic conditions are driving jurisdictions to find other means of remuneration to incent to proactive treatment and monitoring of these underlying conditions
	Interdisciplinary care	Group care models like Family Health Teams (FHT) in Ontario and Family Medicine Group (FHG) in Quebec have been designed to deliver interdisciplinary care
Drug claims	Consultative services	Policies designed to reduce strain on acute and primary health system and increase access for patient allow for pharmacists to bill some provinces for patient counseling an advisory services
	Administration of vaccines	Patients in many provinces across Canada are now able to go to pharmacies in order to receive routine vaccinations such as the flu shot
	Increased use of drug knowledge	Pharmacists are being asked to play a larger role in what prescriptions are dispensed to patients, compensation pharmacists for completing comprehensive medication histories and validation and in some cases, renewing prescriptions for patients
Workers claims	Return-to-work	Workers compensation boards are increasingly assigning case officers to track claimants progress, recovery activities, workforce re-entry or alternative employment options to reduce the number of loss of earnings beneficiaries

What the future holds for health claims

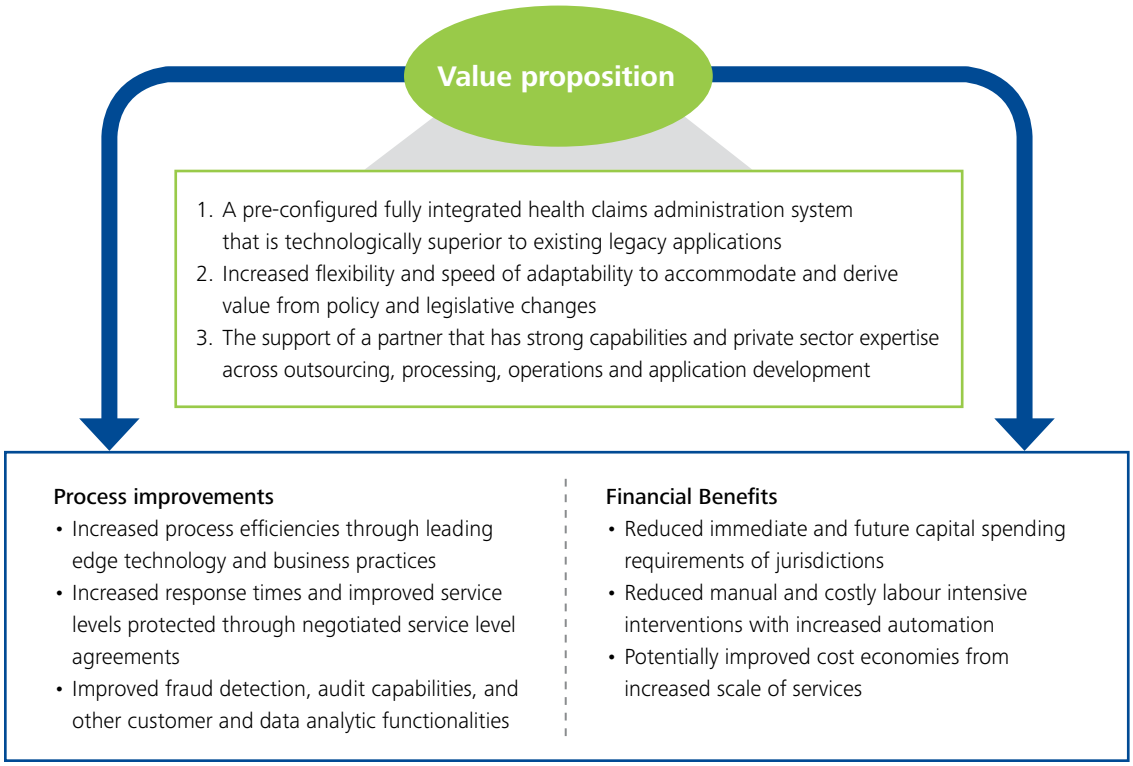
The case for exploring alternative service delivery models

Given the need to improve overall system value for each dollar spent while increasing fiscal restraint, lowering capital investment is a necessary component of all government budgets. To drive these imperatives, increased collaboration with the private sector on certain initiatives can decrease cash outflows in the short-term and realize cost savings and higher service levels in the long-term.[7] With such collaborations, and resulting improved efficiencies, already being seen in other government areas, health claims administration appears an optimal candidate for private sector participation (Figure 4).

To implement new or updated claims administration systems on their own, governments would need to invest heavily in developing the architecture and business rules for the auto-adjudication systems. However, there is ample opportunity to partner with private companies who have already developed comprehensive expertise in health claims systems, thereby decreasing the capital investment required. The private sector can also provide deep subject matter expertise in developing and operating health claims administration programs. Companies that specialize in developing the business rules that comprise an auto-adjudication system can design programs that put less than 5% of all claims through to manual review. They can also incorporate advanced system features such as customer analytics and flexible platforms. Outsourcing the manual claims administration functions is another flexibility option that can improve labour force management and lower labour costs. Finally, governments typically lack core competencies in IT architecture. Outsourcing this function to specialized providers can help develop a more robust underlying operations platform for health claims systems.

There are numerous advantages to increasing collaboration with the private sector on health claims administration. Using the private sector to stymie cash out-flows and provide deep, time-tested industry expertise is a strong strategy for governments looking to realize immediate cost savings and develop superior systems in the future.

Figure 4 – Benefits of health claims transformations



Outsource options available to government

Governments have the option of outsourcing all, a large part or just some of their health claims administration to outside providers. Some governments, such as British Columbia and Manitoba, have chosen to outsource all their health claims administration needs while others, such as Nova Scotia, have outsourced only a part (Figure 5). Outsourcing options include:

Business process outsourcing (BPO)

Back-office functions, typically performed by entry-level employees, are a major resource drain. Activities include manual reviews of claims that cannot be auto-adjudicated, review of claims that are being appealed and customer service activities. These processes are quite labour intensive and comprise between 30%-50% of health claims administration costs. Nova Scotia, British Columbia and Manitoba have all outsourced their manual health claims administration process in order to reduce costs, gain greater efficiencies and reduce capital investment. These operations can be efficiently run outside of the organization.

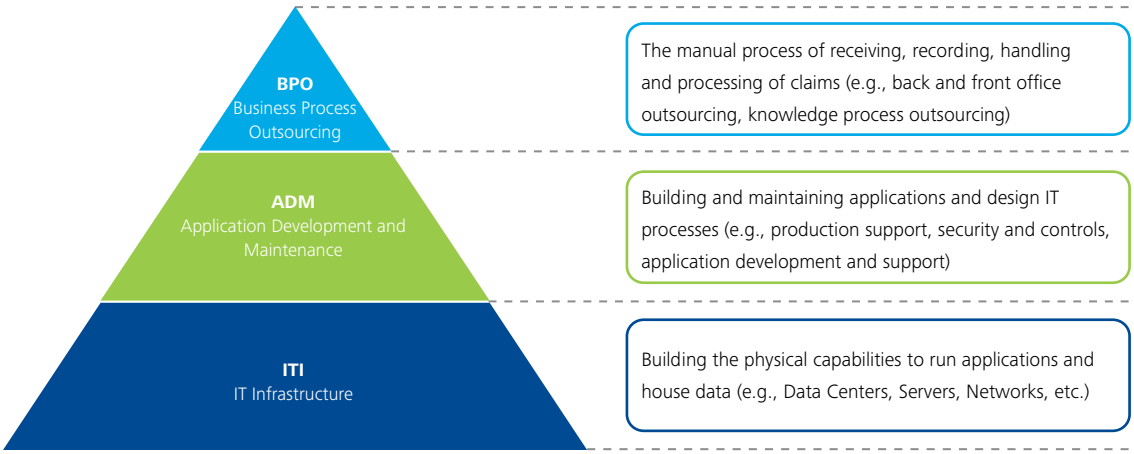
Application development & maintenance (ADM) outsourcing

Claims adjudication systems development requires highly specialized knowledge and generally takes place over a one-to-three-year time horizon. It also requires a high level of capital investment because such systems cannot be fully utilized until fully developed and tested. On top of that, long-term system maintenance involves application support and ongoing incorporation of changes and updates. Outsourcing these tasks to the system developer is common, as their system knowledge lets them incorporate changes in more cost-effectively. Outsourcing the ADM function should allow governments to realize significant savings over the life of their service contracts, with a lower capital investment. In fact, using this approach, some provincial health plans have been able to spread the cost of claims administration system development over the entire ADM period.

Information technology infrastructure (ITI) outsourcing

ITI is the platform on top of which the health claims administration system operates. It is crucial that these systems are secure, robust and incorporate redundancies and backups to avoid any data loss if the system is compromised. Governments typically have not developed core competencies in building and maintaining this type of specialized infrastructure. Outsourcing these services provides access to a network of organizations that specialize in this industry. It also meets lower capital investment thresholds by spreading out the cost of system improvement over a number of years.

Figure 5 – Outsourcing options for health claims administrations



What governments can do today

Assess needs, find a partner, implement a solution

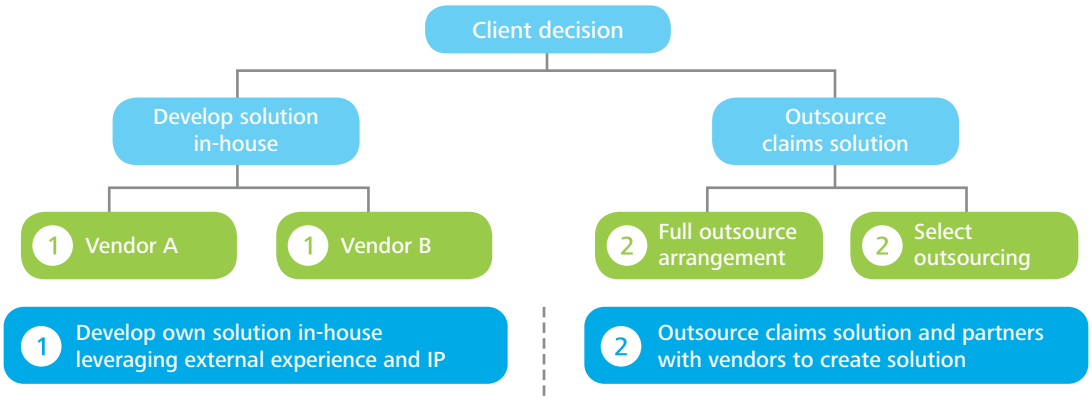
To effectively develop future health claims administration systems, governments must have a clear view into their current and future needs. Recognizing that system needs are driven by policy changes, governments must identify the administrative and technological changes that will derive the greatest system value from health claims. A complete list of the needs and wants of future health claims systems will help governments determine whether they have the right capabilities and appropriate budgets in place. A comprehensive future view will also simplify any necessary system modifications down the road.

Once future system capabilities are defined, governments can determine which components of the health claims value chain – including business processes, application development and maintenance, and information technology infrastructure – should remain in-house. Governments must also decide whether they seek a solution or a service with respect to health claims administration initiatives. A solution leverages private sector partner expertise during the development, build out and go-live phases of a project, with maintenance and ongoing operations left to the jurisdiction. Health claims administration as a service leverages private sector partners for all requirements, both short- and long-term (Figure 6).

Assessing what skill sets and capabilities are in-house; developing business and technical requirements; and scoping the work to be potentially outsourced are fundamental early steps in the search for a private sector partner. Outsourcing solution components means having the appropriate service level agreements, controls and mitigations in place to ensure adequate service levels and successful delivery. It is important that governments reach out to a partner that has a track record of success and can develop a system that is in-line with current and future needs.

Compared to the total expenditures of any health insurance plan, the outlays related to claims administration are relatively small; however, it remains a crucial program component. If the claims processing system is unable to handle the complexities of evolving healthcare policies, change initiatives will never realize their full value. Developing the right system with the appropriate partners can lower overall costs, freeing up capacity and investment capital for other critical system areas. Across the entire health claims world, the need for better analytics and improved system integration is growing. By increasing collaboration with the private sector, governments can address claims administration system needs as part of a broader solution to healthcare challenges, thereby minimizing capital investment, increasing access to development and implementation expertise and unlocking the real value systemic transformation has to offer.

Figure 6 – Health claims solution selection framework



Jurisdiction seeks solution:

- Professional services market historically provides these services as required across vendor solutions

Jurisdiction seeks service:

- Opportunity to offer new service delivery model for health claims processing service bureau

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Endnotes

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Notes

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