Swipeable Insurance Cards Will Reduce Errors, Costs

BY ERIK L. GOLDMAN

DENVER — Incorrect patient identification information is still the No. 1 reason for rejected insurance claims, and the majority of these errors—which cost the nation an estimated $2.2 billion in administrative waste—reflect the failure of the health care industry to embrace standardized, machine-readable magnetic ID cards.

The Medical Group Management Association (MGMA) is hoping to change the situation. Last year, it launched Project SwipeIT, a national, multistakeholder effort to push for full implementation of magnetic insurance ID cards in all public and private health insurance plans.

In its first year, Project SwipeIT garnered pledges of support from more than 1,000 physicians' organizations, insurance companies, and health information technology vendors who vow to issue, support, or accept machine-readable ID cards.

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DR. HEIM

Standards for magnetic insurance ID cards were first developed in 1997. Yet today, health care transactions are still almost entirely dependent on paper or plastic ID cards. Each insurance company has its own card design and format, some of which can be difficult to read or copy.

Stapling a photocopy of a patient's ID card into the medical chart or manually key-stroking information into the patient's record is still the norm in nearly all medical practices.

Reliance on paper-to-paper transfer of identifying information leaves a lot of room for error. Numerals are easily mistaken, names misspelled, benefits changed, and expiration dates unnoted.

The MGMA estimates that 98% of all claims generated by physicians' offices are not electronic, and approximately 5% of those claims are rejected because of incorrect ID information, leading to long and costly delays in physician reimbursement.

On average, it takes roughly 15 minutes of staff time to manually correct and resubmit an erroneous claim once the error has been identified.

The MGMA estimates that outpatient physicians nationwide could save as much as $290 million per year if all insurers used swipe cards in compliance with standards developed by the Workgroup for Electronic Data Interchange.

The American College of Physicians is one of many physician groups that have endorsed Project SwipeIT. Others include the American Academy of Family Physicians, American College of Surgeons, and American Medical Association.

"There's no reason we shouldn't have machine-readable cards at this point," said Dr. Lori Heim, AAFP president. "We are very supportive of this project."

Dr. Heim attributed the failure to adopt swipeable ID cards to "procedural inertia." Though standards for creation of cards have been in place for more than a decade, it has taken more time to develop standards for reader devices, interfaces between card readers and electronic health record systems, and platforms for interoperability.

"It is reflective of the broader problems we've seen regarding the adoption of health care [information technology] in general," she said in an interview.

Without strong consensus and commitment from all major insurers—or an unequivocal federal mandate—individual plans have been unwilling to take the first steps and implement their own swipe cards.

And if the plans weren't going there, neither would physicians, even though both parties stand to gain.

Dr. Heim said that creating standards for transfer of ID card data into electronic health records will be critical for general success. "It's a complex issue because there are so many different EHR systems, and each has its own setup. In order to realize the savings potential, we need the patient ID information to transfer smoothly from the card reader to the right places in the EHR."

Like any other technological innovation, implementation of swipe cards will carry some upfront costs for purchase and installation of card readers and production of the cards themselves. The question of who should bear those costs is an open one at this point.

According to the MGMA, card readers cost around $200 per clinic, and the software upgrades needed to interface card readers with electronic practice management systems are minimal.

Dr. Heim said that she believes the implementation costs should be borne by insurers, who have much to gain by digitizing transactions and reducing errors. "It would significantly reduce the amount of money they have to pay to people for spending time on the phone working out disputes with doctors' offices."

But she will not be surprised if the insurance industry tries to put all or some of that cost on the shoulders of physicians and hospitals. "We will definitely push back on that," she promised.

In 2010, the MGMA and its partners plan to become more active in pushing the Project SwipeIT agenda. According to the group's Web site, the second phase of the project involves publicly recognizing payers that have met their pledges and issued standardized, machine-readable health ID cards, while publicly identifying those that have not. ■

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State Eyes Gift Restrictions

New Jersey's Division of Consumer Affairs has called on state lawmakers to take a variety of steps, such as banning pharmaceutical company–sponsored meals for physicians, in an effort to curb doctors' conflicts of interest when they prescribe drugs. The division urged 22 reforms, most to be enforced by the N.J. Board of Medical Examiners, that would forbid physicians from accepting free trips, gifts, or meals and would require them to disclose any industry payments over $200 for consulting. However, the proposed regulations would continue to allow pharmaceutical representatives to distribute free drug samples. The consumer affairs division also urged new restrictions on the mining of prescriber-identifiable data and said it wants the lawmakers to ban the sale of such data.

FDA Told to Strengthen Monitoring

The Food and Drug Administration has begun to address weaknesses in its oversight of the safety of drugs once they're approved and marketed, but it still hasn't staffed the effort correctly, the Government Accountability Office said. Previously, the congressional watchdog agency reviewed the regulatory history of the drug Vioxx (rofecoxib), which was pulled from the market in 2004 after being linked to heart attacks and strokes. At that time, the GAO recommended changes in the FDA's program to monitor drugs after they are approved, including clarification of various offices' roles in that effort. However, the GAO said last month that the FDA still does not have a timetable for making those changes. The report called for a comprehensive plan showing which FDA office is responsible for monitoring approved drugs on the market.

Asthma Projects Are Launched

The National Heart, Lung, and Blood Institute has awarded 13 contracts to local organizations to test new evidence-based approaches to managing asthma. The 2-year contracts, worth $1.3 million in total, are part of the National Asthma Control Initiative, which is to strengthen collaborative efforts among patients and families, health care providers, and others involved in managing asthma. The 13 projects include a range of asthma interventions in diverse communities. For example, one will work to reduce asthma triggers in homes and schools, while another will provide Web-based training programs and in-person education for both patients and providers.

Health Centers Get $600M Boost

A total of 85 community health centers in more than 30 states will receive nearly $600 million in American Recovery and Reinvestment Act awards to support expansion through construction and renovation projects and acquisition of health information technology. The awards should help the centers care for more than 500,000 additional patients in underserved communities, said President Obama, who announced the initiative. At the same time, the Centers for Medicare and Medicaid Services will test the impact of the medical home practice model in community health centers, focusing on access, quality, and cost of care for Medicare beneficiaries, President Obama said. Up to 500 centers will eventually participate in the 3-year medical home demonstration, according to the CMS.

Information Tech Gets Funding Too

The recovery act also will fund $235 million in grants to strengthen the existing health information technology (HIT) infrastructure and increase information-exchange capabilities, according to the Department of Health and Human Services. The Beacon Community Program will fund 15 initiatives run by nonprofit organizations or government entities that already have HIT systems in place with wide adoption of electronic medical records. The goal of the program is to show how cutting-edge HIT programs can improve quality, safety, efficiency, and population health while maintaining strong privacy and security measures, the HHS said. The results from the grant program will provide guidance for the use of electronic medical records throughout the United States, the primary goal of the federal government's HIT initiative.

Transparency Law Falls Short

Uninsured patients in California are unable to obtain information about the cost of medical care at hospitals, despite recent state legislation designed to improve price transparency, according to a study published in the Journal of General Internal Medicine. For the study, researchers posed as low-income, uninsured patients and asked hospitals for price information. They received estimates from fewer than one-third of the hospitals approached, and the prices given often were much higher than those allowed under California law, which forbids hospitals from charging the uninsured more. In addition, the prices for procedures varied widely—for example, the quotes for a colonoscopy ranged from $216 to $1,748. "Few of the estimates we did receive allowed us to make an 'apples to apples' comparison between different hospitals," said lead author Dr. Kate Farrell of the University of Pittsburgh. The other researchers in the study are with the RAND Corp., the California HealthCare Foundation, and Brown University, Providence, R.I.

—Jane Anderson