Center for Health Care Purchasing Improvement (CHCPI)

Annual Report

(January 2008 - December 2008)

Report to the Minnesota Legislature 2009

Minnesota Department of Health

May, 2009

MINNESOTA MDH DEPARTMENT OF HEALTH

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Center for Health Care Purchasing Improvement (CHCPI) Annual Report
(January 2008 – December 2008)

Summary

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 43A.312. The report encompasses the period January – December 2008.

The State of Minnesota currently purchases health care services on behalf of over 785,000 Minnesotans at costs of over $5.1 billion annually[i] – the single most rapidly growing component of the state budget. The CHCPI was established in late July, 2006 following enactment of Minnesota Statutes, section 43A.312 during the 2006 legislative session. The Center serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services" and is authorized to participate in other related health care improvement activities, including simplification and streamlining of health care administration. It is funded through an annual base appropriation of $130,000.

A variety of studies have characterized the current health care delivery and financing system as disjoint and fragmented, with variable or often poor quality, and burdened by skewed payment incentives that do not align for optimum value and performance.[ii] At the same time, even routine health care business transactions, such as submitting claims for payment, are often non-standard and overly burdensome or expensive. Greater alignment of appropriate incentives and practices are needed to improve not only the delivery and outcomes of health care services, but to decrease administrative costs and burdens as well

During the period covered by this report, the Center primarily oversaw development and adoption of first-in-the-nation rules to streamline and standardize high volume, routine health care transactions. The rules require that these transactions be exchanged electronically, using a single, uniform data content and format. They apply to more than 60,000 health care providers statewide as well as more than 2000 "group purchasers" (payers) licensed or doing business in Minnesota. The rulemaking process is complex, is being undertaken in consultation with a large, voluntary group of stakeholders known as the Minnesota Administrative Uniformity Committee (AUC) and other industry representatives, and is being completed to meet very tight statutory deadlines.

We are pleased to report that as required by statute, rules for three types of health care administrative transactions were successfully developed, promulgated, and adopted in consultation with the AUC in 2008, on time and on budget. When fully implemented, the rules will reduce overall health care administrative costs throughout the system by more than $60 million annually, allowing more of every health care dollar to be spent on patient care and health improvements.

In 2008, the Center also initiated an additional legislatively required study of health care administrative simplification, and coordinated and staffed several other related health reform activities. The remainder of this report describes in greater detail the Center's primary rulemaking responsibilities and accomplishments, and other efforts and activities of the Center during 2008.

Center for Health Care Purchasing Improvement (CHCPI)
Annual Report

(January 2008 – December 2008)

I. Introduction

A. Annual Report

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) encompasses the period from January – December, 2008. This report is being submitted to fulfill the requirements of Minnesota Statutes, section 43A.312, that

> *"The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health Web site and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement."*

B. CHCPI Background

The State of Minnesota currently purchases health care services on behalf of over 785,000 Minnesotans at costs of over $5.1 billion annually – the single most rapidly growing component of the state budget. The Center for Health Care Purchasing Improvement (CHCPI) was established by the 2006 Legislature with the enactment of Minnesota Statutes, section §43A.312, to "*support the state in its efforts to be a more prudent and efficient purchaser of quality health care services."*

The Center's enabling statute further provides that the Center may undertake a variety of activities with "the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies." These activities include for example:

- "support the Administrative Uniformity Committee under section 62J.50 and other relevant groups or activities to advance agreement on health care administrative process streamlining";
- "initiate projects to develop plan designs for state health care purchasing";
- "contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance".

The CHCPI was initially established and administered as a unit of the Department of Employee Relations (DOER). However, in January, 2007 Governor Pawlenty announced that DOER would be merged with other state agencies. Legislation enacted in 2007 clarified that the "duties

relating to health care purchasing improvement under Minnesota Statutes, section 43A.312, are transferred on or before June 1, 2008, to the commissioner of health."[iii] The transfer of the Center to the Minnesota Department of Health (MDH) was officially made on July 29, 2007, and CHCPI now operates as a section within the MDH Health Policy Division.

The Center is funded through a base appropriation of $130,000. As prescribed in statute, the CHCPI is staffed by a Director, who was appointed in late July, 2006. For a period in 2006 to early 2007, it housed two additional staff. At present, the Center includes the Director and one additional staff member to assist in coordinating and staffing health care administrative simplification efforts described later in this report. Consulting and other costs in excess of the base appropriation have been funded using additional budget sources.

II. CHCPI OPERATIONS, ACTIVITIES, AND IMPACTS

A. Health Care Administrative Simplification and Savings

Greater alignment of appropriate incentives and practices is needed to improve delivery and outcomes of health care services, to improve health care administrative functions, and to reduce administrative costs. As discussed below, the CHCPI built on work initiated in 2007 and developed even more extensively in 2008 to coordinate and support a first-in-the-nation effort to reduce health care administrative costs and burdens.

1. Overview

Health care has lagged far behind the financial, transportation, and other sectors of the economy in its use of efficient, effective, standard electronic exchanges of routine business transactions. The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient, much more burdensome, and much more costly to the health care system.

Studies have shown that exchanging common health care administrative transactions on paper, or in nonstandard formats, is more expensive than standard, electronic data exchanges and can result in problems of incomplete or incorrect information that cause delays and further expense. One recent national study estimated that the costs of processing paper health care claims (billings) at $1.58 per claim, or nearly double the cost of electronic billings, at 85 cents per claim.[iv] A 2006 report estimated that between $15.5 and $21.8 million is spent annually in Minnesota for follow-up telephone calls between health care providers and payers to resolve questions related to patient eligibility for insurance coverage and benefits and health care claims.[v]

Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur every minute, every day, millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity. As described below, the CHCPI is playing an important role in

implementing requirements that administrative transactions be exchanged electronically, using a standard data content and format, to reduce overall administrative costs in Minnesota's health care system by more than $60 million per year by 2013.[vi] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to also meet other goals for health care performance measurement and improved patient care.

In late 2006 the CHCPI responded to interests on the part of Governor Pawlenty's Health Cabinet to explore opportunities for rapidly aligning efforts to streamline and simplify routine health care administrative transactions. In December 2006, the Center planned and staffed a site visit to a promising example of alignment for health care administrative simplification in Utah, known as the Utah Health Information Network (UHIN). Minnesota's site visit delegation included nearly twenty state and private sector representatives, which met with a similar large contingent from UHIN for two days of discussion and information exchange.

The site visit led to broader discussions and momentum for changes in Minnesota to accelerate health care administrative simplification and standardization efforts. That interest culminated in the 2007 legislative session with passage of Minnesota Statutes, section 62J. 536 -- first-in-the-nation legislation requiring that all health care providers and group purchasers (payers) exchange three types of common health care business transactions electronically, using a single, uniform data content and format, by 2009.

2. <u>CHCPI leads first-in-the-nation rulemaking for health administrative simplification; rules adopted on time and on budget</u>

a) Rules Timeline

Minnesota Statutes, section 62J.536 further requires that the Minnesota Department of Health (MDH) adopt rules for the data content and format standards to be used in the exchange of the administrative transactions. The rules are to be promulgated at least one year in advance of the dates that they take the effect of law, as shown in the table below.

Health care transaction	**Rule Promulgation Deadline**	**Rule Implementation (Rule has the force of law)**
Eligibility Inquiry and Response	January 15, 2008	January 15, 2009
Claims	July 15, 2008	July 15, 2009
Payment remittance advice	December 15, 2008	December 15, 2009

b) Rules are based on federal HIPAA regulations and Medicare, in consultation with large stakeholder group, the Minnesota Administrative Uniformity Committee (AUC)

The statute further specifies that the rules be based on federal Health Insurance Portability and Accountability Act (HIPAA)[vii] transactions and code sets requirements and the Medicare program, with modifications the Commissioner of Health finds appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC). The AUC is a broad-based, voluntary group representing Minnesota's public and private health care payers, hospitals, health care providers and state agencies. It has served since 1992 to develop agreement among payers and providers on standardized administrative processes. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. It meets as a large committee of the whole, as well as through numerous work groups and Technical Advisory Groups (TAGs). The work groups and TAGs reflect particular areas of expertise and divisions of labor with respect to different types of health care administrative transactions and processes.

In addition to the statutory deadlines above, CHCPI and the AUC developed an additional process to provide for a review of the rules six months after their adoption, but six months before they take the effect of law, for any possible clarifications, technical updates, or changes that may be indicated with preliminary experience and testing of the rules. The Center and the AUC also plan for annual in-depth reviews and maintenance of the rules, as well as any revisions that may be needed to conform with changes to federal HIPAA transactions and code set regulations.

c) The Center's primary responsibility in 2008 was to oversee MS § 62J.536 rulemaking process

Since passage of Minnesota Statutes § 62J.536, and with the transfer the Center to MDH, the Center's primary responsibility has been to serve as project manager to coordinate the rule development process**.** The rulemaking has been unprecedented and complex, requiring significant technical input of affected stakeholders, as well as substantial outreach and communication to inform health care providers, payers, and others of the legislation and rules, within a very short timeframe. It has leveraged hundreds of hours of non-state, in-kind expertise across several dozen health care provider, payer, and other technical subject matter experts, business specialists, computer systems experts, and others affiliated with the AUC and interested parties.

During 2008, the Center oversaw and participated in the rulemaking effort through:

- <u>Active support of and consultation with the AUC</u>

  The CHCPI provided a significant level of planning, coordination, research, staff support, liaison and communications to *over 130 regularly scheduled and ad-hoc meetings of the AUC governance structure and its technical advisory groups, work groups, and others.* Some AUC work groups met as often twice a week for several months in order to meet the statutory timelines, with frequent additional emails and phone calls between meetings to discuss and resolve issues. The meetings addressed technical and policy issues related to the rule development and implementation.

- Convening and staffing a special, nationally publicized meeting to address issues related to non-HIPAA covered entities

  The Center planned, organized, and staffed a large meeting to help identify rules-related issues for workers' compensation, property and casualty, and auto insurance carriers. These carriers are not subject to federal HIPAA administrative simplification requirements but must now comply with the new state law and rules. As a result, the MDH-AUC rulemaking process must also identify and address possible business information needs or other needs that may be unique to these carriers. The meeting was attended by representatives of non-HIPAA covered entities from around the nation, and provided significant information and expertise to aid development of rules for the claims remittance advice transaction.

- Rapidly organizing and facilitating development of a single, coherent state response to federal request for comments on proposed new versions of HIPAA transaction standards

  CHCPI provided resources for an outside consultant, as well as coordination and staffing to the AUC, to rapidly respond to a federal Notice of Proposed Rulemaking (NPRM) request for public comments regarding proposed rules. In August, 2008, the federal Centers for Medicare and Medicaid Services (CMS) announced proposed rules for new versions of federal HIPPA transactions standards (known as "ANSI X12 5010" and "NCPD D.0") and solicited public comments regarding the proposal. The Center rapidly organized, resourced, and staffed special meetings of the AUC and other interested parties in September 2008 to develop a single, comprehensive, coordinated, statewide response to CMS to meet an October 20, 2008 submission deadline.

- Rule-related communications, outreach, and technical assistance, both singly and in collaboration with the AUC

  The Center worked independently and in combination with the AUC and other stakeholders, to produce a range of information and communications about the administrative simplification effort, including:

  - maintenance of a large email distribution list for periodic updates, news, and information of interest;
  - provider and payer alerts;
  - participation in and contributions to over 19 industry educational forums;
  - articles and issue briefs for publication;
  - submissions to the State Register;
  - materials for two websites;
  - AUC newsletters;
  - answers to frequently asked questions (FAQs); and
  - a large volume of responses to individual emails, letters and phone calls.

We are pleased to announce that as a result of the efforts described above, the statutory requirements of Minnesota Statutes 62J.536 have been met on time and on budget. In 2008, CHCPI, in consultation with the AUC, coordinated the promulgation, adoption, or technical updates for fifteen sets of rules known as "Minnesota Uniform Companion Guides" for three

types of common health care administrative transactions. During this time, the Center also helped lay the groundwork needed for additional rule updates and other health care administrative simplification efforts in 2009.

3. Additional health care administrative simplification through adoption of "Best Practices"

In addition to overseeing development and implementation of the rules above, the CHCPI staffed the AUC in the development of eleven "best practices" which do not have the force of law, but represent industry consensus on practical, preferred approaches to best resolve additional transactions issues at this time.

For example, payers may require that certain types of supplemental information, such as X-rays or other medical information, accompany claims for payment. There is no HIPAA national standard for electronically exchanging this information, which is typically now sent via fax or other non-electronic means. The AUC developed a best practice for exchanging claims attachments, including: information to include on an electronic claim to indicate that an attachment is also being submitted to accompany the claim; instructions for providing tracking numbers to match attachments with claims; and, a standard fax cover sheet to accompany the attachment.

The goal of the best practices is similar to the rules – to standardize and simplify routine health care business transactions in order to reduce their costs and administrative burden. Over time, it is possible that the best practices may be adopted as part of Minnesota's rules for the standard, electronic exchange of health care administrative transactions.

B. CHCPI leads legislatively mandated study of Uniform Claims Review Process for completion in 2009

1. Overview

As part of a large health reform bill signed into law in 2008, MDH is completing a study of "Uniform Claims Review Process" in which, as described below:

The commissioner of health shall establish a work group including representatives of the Minnesota Hospital Association, Minnesota Medical Association, and Minnesota Council of Health Plans to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate payers. The work group shall make its recommendations to the commissioner by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.
(Laws of Minnesota, 2008 Regular Session Chapter 358--S.F.No. 3780, Article 4, Sec. 13.)

The Center was assigned the lead MDH role in convening and facilitating the study. CHCPI organized an initial project planning meeting with representatives of the Minnesota Council of

Health Plans, Minnesota Hospital Association, and the Minnesota Medical Association in August 2008. The group reviewed the study charge and identified preliminary potential interests and priorities for further subsequent review and development, including: universal pricing concepts; possible administrative improvements to the current health care delivery and payment system, and business transactions to support new and emerging types of health care services and service delivery.

2. Preliminary study background for possible further review and discussion

Following the initial planning meeting, CHCPI identified other possibly relevant studies and efforts for discussion and review at subsequent meetings. In particular, it examined and summarized for subsequent discussion: a previous report by a collaboration of the three groups identified in the study charge above, known as "Administrative Simplification Work Group (ASWG)"; and reports and press releases from the 2008 "Heal the Claim Process" initiative of the American Medical Association (AMA).

The ASWG completed a preliminary study in 2006 with the four goals below:

- Provide a framework for providers and payors to address complex and costly administrative issues;
- Identify and prioritize savings opportunities through administrative simplification activities;
- Develop realistic timelines to jointly implement solutions among payors and providers; and,
- Create methods to monitor administrative simplification activities and outcomes across the Minnesota healthcare community.[viii]

A key finding of the ASWG study was that manual processing and phone time to track and resolve administrative issues clearly represented significant components of overall health care administrative costs. The work group identified the following areas of focus with the greatest opportunity for administrative simplification:

- Eligibility verification;
- Claims status inquiry;
- Clarifying adjudicated claims; and,
- Paper claim submissions.

Many of the ASWG's findings added momentum for the passage of Minnesota Statutes 62J.536 in 2007, and remain of possible interest as part of the Uniform Claims Review Process study and for possible future development with the AUC.

The other primary background resource identified for the Uniform Claims Review Process study was the American Medical Association's (AMA's) "Heal the Claims Process" initiative. This initiative was announced by the AMA in 2008, to address what it found to be a costly, "inefficient and unpredictable system of processing medical claims". The AMA reported that "…physician practices are spending as much as 14 percent of their total collections to ensure accurate payment for their services" and that "the current state of affairs is costing medical

providers and health insurers about $20 billion – about ten billion for each side – in unnecessary administrative expenses".[ix]

The AMA identified several factors that it felt contributed to the problem of undue administrative burden and expense. It conducted a study of the performance of large national payers in processing medical claims and published a subsequent "report card" on the results of its study. In a press release summary of the report card the AMA reported several factors in particular that it felt contributed to the problem, including:

- Claims denials;
- Contracted payment rate adherence;
- Transparency of fees and payment policies;
- Compliance with generally accepted pricing rules; and,
- Payment timeliness.[x]

The ASWG and AMA reports will be further reviewed and discussed at later planned meetings of the Uniform Claims Review Process study project. Of special interest may be considerations of possible impacts of the current rulemaking for standard, electronic health care administrative transactions discussed above on issues raised in the 2006 ASWG report or the national AMA initiative.

Due to the need for CHCPI and stakeholders to meet the statutory deadlines for rulemaking described above, further meetings of the study were postponed until 2009. CHCPI and the work group will review the background studies above, and other pertinent information, and continue to address the study charge in the context of Minnesota's current health care reform efforts.

In late 2008, CHCPI also worked with the MDH Health Economics Program (HEP) to expand an HEP Request for Proposals (RFP) seeking consulting assistance on a variety of health reform activities. The expanded RFP includes provisions for consulting on the "uniform pricing" provisions of the Uniform Claims Review Process study. It is anticipated that the RFP process and vendor selection will be completed in the first quarter of 2009, to facilitate further work on the uniform pricing provisions of the study charge beginning the second quarter of 2009.

C. Other CHCPI activities and accomplishments

1. Coordination and planning with other health care reform efforts

The CHCPI's administrative simplification efforts are closely related to other ongoing health care reforms underway at MDH. In particular, MDH is working with a variety of stakeholders and experts to implement: electronic health records by 2015; e-prescribing by 2011; and a series of innovative new payment reforms based on health care cost and quality measures and prototype new forms of bundled of health care services. These new forms of service delivery include "baskets of care" and "medical homes", as well as collection of health care encounter data for "provider peer grouping" to aid cost and quality analyses and comparisons. In order to successfully develop and implement these reforms, a variety of operational and administrative issues must be addressed, including how new types of health care services will be coded and

billed, and the relationship between the rules for standard, electronic transactions and the additional health care reform requirements.

To help address these issues, in 2008 the Center:

- Participated as part of an "e-prescribing work group" of the Minnesota e-Health Advisory Committee to help coordinate the requirements for standard, electronic health care transactions and requirements specific to e-prescribing;
- Met with MDH's Health Economics Program (HEP), which is leading many of the other related health care reform efforts, to coordinate on operational and administrative issues in implementing the cost, quality, and payment reforms;
- Worked with the AUC to plan and coordinate its input in the health reform process. It is anticipated that the CHCPI and the AUC will also be more closely involved in ongoing operational and administrative questions of implementing baskets of care and other reforms in 2009.

2. Center presentations, exchanges of best practices, and outreach at the national level

In 2008, the Center participated in and contributed to several national level health care purchasing and health care reform presentations and exchanges of best practices, including:

- Participation in national web-based seminar (webinar) on "*Aligning Incentives for Quality with Insurers and Providers"*

  The Center was invited and subsequently participated in a national webinar on "*Aligning Incentives for Quality with Insurers and Providers"* in June 2008. The webinar was sponsored by the Commonwealth Fund and administered by the Brookings Institution and the National Academy for State Health Policy. The Center's presentation focused on the Director's previous experience with the Minnesota State Employee Group Insurance Program health benefits program "Advantage". Advantage was of interest to the national audience as an example of a tiered health care purchasing model that provides state employees and their families with important information on the costs and quality of health care providers to aid in health care decisions.

- Provided materials for "World Health Congress", April 2008

  The CHCPI produced materials for a presentation by Cal Ludeman, Commissioner of the Minnesota Department of Human Services, and Chair of the Governor's Health Cabinet, regarding the Minnesota Advantage program above for a presentation on "Benefit Design Innovations" at the World Health Congress in Washington, D.C., April, 2008.

- Provided background and information, Governor Pawlenty testimony to before the U.S. House of Representatives, Committee on Small Business, February 26, 2008

  The Center provided information and background for the Governor's testimony before the U.S. House of Representatives, Committee on Small Business, February 26, 2008, regarding health care costs and health care reform efforts.

- Provided background and information, Governor Pawlenty "Modern HealthCare" article (for 2009 publication)

The Center provided information and background for an article by Governor Pawlenty on health care reform for "Modern HealthCare" (for publication 2009).

- Invited (and invitation accepted) to present at National Council of Prescription Drug Programs (NCPDP) conference, Dallas, Texas, February 2009

  The CHCPI accepted an invitation to present to a national meeting of the National Council of Prescription Drug Programs (NCPDP), the national standard setting organization for the electronic exchange of prescription drug information. The Center will present an overview and updates on Minnesota's e-health initiatives, including health care administrative simplification, requirements for and implementation of electronic health records, and e-prescribing requirements and implementation.

III. Anticipated Center Activities and Priorities for 2009

At this time, it is anticipated that the Center will be undertaking the following for 2009:

- Continued development and implementation of rules for standard, electronic health care transactions.

  In consultation with the AUC, CHCPI will:

  - prepare and implement any technical updates and changes for the health care payment remittance advice transaction rules prior to December 15, 2009;
  - review new "ANSI X12 5010" and "NCPDP D.0" versions of federal HIPAA transactions standards and develop possible changes to current rules that are needed to conform to the new versions to be required nationally January 1. 2012.
  - promulgate and adopt rules as needed to implement any changes needed in Minnesota's administrative simplification requirements.

- Additional outreach, communications, and technical assistance to aid awareness and compliance with the rules for standard, electronic health care transactions

  The Center will be issuing an "informal solicitation" in early 2009 seeking consulting expertise to help develop and disseminate information and technical assistance to aid health care providers and group purchasers (payers) to be aware of the rules and to aid compliance. The outreach and technical assistance will be particularly focused on aiding solo providers or providers operating in small groups, and payers currently not covered by federal HIPAA regulations, including workers' compensation, property and casualty, and auto insurance carriers.

- Uniform Claims Review Process Study

  The Center will undertake further development of the study objectives and recommendations to meet the statutorily requires January 1, 2010 reporting requirement.

- Continued development and refinement of "best practices" to help reduce administrative burdens and costs

The Center will assist ongoing work with the AUC in developing and communicating additional best practices to help reduce health care administrative burden and costs.

- Continued integration and coordination with other health care reform efforts

  The CHCPI will continue to work with other MDH units and the AUC to coordinate the rulemaking for standard, electronic health care transactions with other health care reform efforts, including e-health initiatives and other improvements in health care cost and quality. In particular, these efforts will be targeted to address key operational and implementation questions about billing and coding of new types of services, harmonization of standards, and other related questions.

- Continued outreach and communications regarding health care administrative simplification, health care purchasing, and health care reform at the local, regional, and national levels

  CHCPI will continue to provide communications, outreach, and exchange of best practices and experiences regarding health care reforms and innovations.

- Respond to additional legislative studies or other needs

  The Center will continue to respond to any possible additional legislative studies and other needs or opportunities to continue to advance more effective health care purchasing and health care administration.

Endnotes

[i] Source: Minnesota Department of Human Service (DHS) and the Minnesota Department of Management and Budget (MMB), personal communications, March, 2009. DHS reports an enrollment of over 670,000 members, at annual state and federal costs of over $4.5 billion. MMB reports over 115,000 members, at annual costs of over $.6 billion.

[ii] See for example reports and studies such as Crossing the Quality Chasm: A New Health System for the 21st Century , Institute of Medicine, 2001 at http://www.nap.edu/openbook.php?isbn=0309072808; Report of the Minnesota Citizens Forum on Health Care Costs, February 2004 at: http://www.minnesotahealthinfo.org/other/citizensforum.pdf and resource material provided as part of the Governor's Health Care Transformation Task Force at: http://www.health.state.mn.us/divs/hpsc/hep/transform.

[iii] Minnesota Session Laws, 2007 Regular Session, Chapter 148, Article 2, Sec. 80.

[iv] Source: An Updated Survey of Health Care Claims Receipt and Processing Times, May, 2006. AHIP Center for Policy and Research at http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

[v] "2006 Administrative Simplification Project – Project Documentation. Nov. 10, 2006".

[vi] Center for Health Care Purchasing Improvement (CHCPI) analysis, January, 2008.

[vii] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for: maintenance of health insurance coverage after leaving an employer; and standards for health-care-related electronic transactions. While HIPAA provided important standardization of electronic health care transactions, it did not address all standardization issues. Requirements of Minnesota Statues, section 62J.536 further harmonize and clarify HIPAA standards, for group purchasers and health care providers to exchange health care administrative transactions electronically.

[viii] "2006 Administrative Simplification Project – Project Documentation. Nov. 10, 2006".

[ix] From AMA "Follow that Claim" posted at http://www.ama-assn.org/ama1/pub/upload/mm/368/follow-that-claim.pdf and AMA "Health insurers' report cards show need for improvement" posted at http://www.ama-assn.org/ama1/pub/upload/mm/368/nhirc-flier.pdf.

[x] AMA press release, June 16, 2008. AMA Launches Campaign To Cut Waste From Chaotic Insurance Claims Process, Unveils New Health Insurer Report Card. http://www.ama-assn.org/ama/no-index/news-events/18672.shtml