TESTIMONY

Before the

Special Committee on Aging
United States Senate

on

Regulatory Implementation Repercussions Stemming from the Health Insurance Portability and Accountability Act (HIPAA)

Presented by:

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Mr. Chairman, I am Alissa Fox, Executive Director, Policy for the Blue Cross and Blue Shield Association (BCBSA). I appreciate the opportunity to testify today on administrative simplification implementation issues. BCBSA represents 42 independent Blue Cross and Blue Shield Plans (Plans) across the country that together provide health coverage to almost 89 million people, one in three Americans.

BCBS Plans are committed to the goals of administrative simplification: reduce administrative costs and complexities of the health care system in order to minimize hassles and paperwork for providers.

My testimony focuses primarily on the HIPAA Transactions and Code Sets Regulations (T&CS) and covers six areas:

1. The current state of industry readiness is extremely low to meet the October 16, 2003 compliance date for the HIPAA transactions and code sets regulation (T&CS), requiring payers to deploy "back up" contingency arrangements.
2. BCBSA is concerned that some entities are attempting to unravel the standards and circumvent the established process for obtaining changes to HIPAA standards by seeking HHS guidance contrary to the intent of the law.
3. BCBSA and its member Plan's have worked to provide industry leadership and provider outreach throughout T&CS implementation period.

4. Important lessons can be learned from implementing the initial HIPAA standards which should be considered before additional standards are adopted.
5. Policymakers are now advocating the next phase of national health care information standards -- “HIPAA II” – for clinical information and interoperability of health care systems. These initiatives are proceeding in an uncoordinated, piecemeal and inefficient fashion, which will increase spending and waste industry resources.
6. The creation of a high-level stakeholder commission is urgently needed to develop a national health care information technology strategy based on industry consensus.

Background

The Health Insurance Portability and Accountability Act (HIPAA) was enacted into law in 1996. The administrative simplification provisions of HIPAA required the Department of Health and Human Services (HHS) to adopt standards in the following areas: healthcare transactions and code sets; privacy of individually identifiable health information; security of health care information; and national identifiers for providers, employers and health plans. The law provides a 24-month implementation period after each regulation is adopted before health plans, clearinghouses, and providers that electronically transmit health care information must comply with the law.

On August 17, 2000, the Department of Health and Human Services issued final rules for the standardization of the form and content of the following electronic healthcare transactions:

- Claims and encounter transactions
- Coordination of benefits;
- Enrollment and disenrollment;
- Eligibility inquiries and responses;
- Payment and remittance advice;
- Premium payments;
- Claims status inquires and responses;
- Referral authorizations; and
- Retail pharmacy.

In addition to transaction formats, the rule also requires the use of certain code sets within the transaction – both clinical codes (i.e., ICD-9, CPT-4) and transaction codes (i.e., gender, relationship of patient to subscriber). Covered entities were originally required to be compliant by October 16, 2002.

However, in December of 2001, the Administrative Simplification Compliance Act (ASCA), provided a 12-month extension of the transactions and code sets deadline. To help ensure compliance, the bill required covered entities to file a "compliance extension plan' with HHS by October 2002. The law also requires all but very small providers and those exempted by the Secretary of HHS to file

claims electronically with Medicare by October 16, 2003. Drafters of the legislation believed that this would improve industry compliance and encourage covered entities to better understand the requirements and tasks needed to come into compliance one year in advance of the new deadline.

Four of the seven initial HIPAA rules have been finalized. HHS is expected to issue additional HIPAA rules over the next year, including a final rule for the national provider identifier and proposed rules for national health plan identifiers and the claims attachment transaction. HHS is also expected to publish a second modification to the transaction and code set rule in Spring 2004. In addition, HIPAA gives HHS discretion to adopt additional financial and administrative transactions – beyond the initial HIPAA rules -- to promote efficiency in the healthcare system.

I. Current state of industry readiness is extremely low to meet the October 16, 2003 compliance date for HIPAA transactions and code sets rule, requiring payers to deploy contingency arrangements.

In July, HHS issued enforcement guidance that allows health plans to accept non-standard transactions, in addition to fully HIPAA compliant transactions, during an interim period as part of a good faith compliance effort. These "contingency plans" are necessary because a significant number of providers and plan trading partners will not be ready to meet the October 16 compliance date

for the transactions and code sets rules. Under HIPAA, payers can only accept fully HIPAA compliant electronic claims or paper claims. We are pleased that the recently issued HHS guidance will allow payers to accept existing formats during an interim period if they can demonstrate "good faith compliance." This will prevent cash flow disruptions for providers.

For many plans, operating dual systems – existing and HIPAA compliant systems – will further increase the cost and administrative burden of the HIPAA regulations. In 2001, the Robert E. Nolan Company (Nolan) issued a report commissioned by BCBSA that projected the cost of HIPAA transactions and code sets for health plans, hospitals and physicians to be $16 billion. While we have not re-estimated those costs at this time, the Nolan projection for large health plans spending-- $10 million--, appears to be on the low side and therefore the actual industry costs is likely to be significantly higher than the earlier $16 billion estimate. In fact, many Plans have indicated that the cost of transactions and code set regulations have equaled the amount spent on Y2K.

Before HIPAA, Blue Cross Blue Shield plans were already highly automated. Approximately, 90 percent of hospital claims and 60 percent of physician claims were submitted and adjudicated electronically. A substantial increase in paper transactions will dramatically increase costs and resources for HIPAA implementation. One plan has estimated it costs $2.00 more per claim to process paper vs. electronic claims. Another plan has reported an increase in

paper transactions already. Worse yet, some of these paper claims are hand written and therefore unable to be electronically scanned for input into adjudication systems.

Provider readiness has been slowed by lack of awareness and considerable misinformation about the ability of vendors and clearinghouses to make providers compliant coupled with the fact that many clearinghouses and vendors will not reach compliance by the deadline. A spring Healthcare Information and Management Systems Society/Phoenix Health Systems (HIMSS/PHSS) survey indicated that just 50 to 60 percent of clearinghouses and vendors are likely to be ready to accept/transmit HIPAA-compliant transactions by the October 2003 deadline.

According to the HIMSS/PHSS survey, respondents stated that "not enough time" was the primary roadblock to HIPAA compliance. Two years ago, BCBSA took an active, leadership position advocating for an extension of the original October 2002 compliance date because of the cost and complexity of the rule and the lack of provider and vendor readiness to meet the compliance deadline. The extension was also important because it provided needed time for HHS to publish, and the industry to adopt, the 4010A1 version of the standard, which was necessary to avoid serious operational issues posed by the original version (4010).

II. BCBSA and member Plans are committed to HIPAA administrative simplification and its national uniform standards, however, we are concerned that some entities are attempting to unravel the standards and circumvent the established process for obtaining changes to HIPAA standards by seeking HHS guidance contrary to the intent of the law.

Many organizations greatly underestimated the cost and complexity of the HIPAA transactions and code sets rule. Ironically, some of the very organizations that opposed the legislation to extend the compliance date back in 2001 because they were "ready" have told Plans now that they are not compliant. Some other entities have presented arguments to HHS that health plans must accept and process claims without all the data requirements mandated by HIPAA. These arguments are being advanced because some health care providers cannot produce the required data necessary to transmit a HIPAA compliant electronic claim by the October deadline. These organizations want HHS to "clarify"take an interpretative position that payers should be required to accept claims with just a subset of the HIPAA required data. These eleventh hour attempts to change the intent and objectives of HIPAA will undermine the law and defeat the purpose of national uniform standards. The result will only serve to punish the entities that have spent the time and money to meet the requirements of HIPAA in accordance with the regulations and HHS guidance. To allow providers to submit, and require health plans to accept transactions without all required HIPAA data is unworkable for many payers.

Payers have invested extensive dollars and human resources to be fully compliant by October 2003 as required by law. To implement partial compliance would require additional staff effort and expense and would require months of systems rework. Many Plans believe they would have to build and maintain a second system, thereby running three systems (one for fully compliant submitters, one for partially compliant submitters, one for those submitters using existing formats.) Allowing providers to submit claims without all HIPAA required data will lead us right back to the current environment – different data requirements for every health plan.

HIPAA provides a process by which any individual or entity may request a change to the transactions through designated standards maintenance organizations. We believe that this process must be followed and any attempt to change the standards through "guidance" should be opposed.

III. BCBSA and its member Plan's have worked to provide industry leadership and provider outreach throughout the T&CS implementation period.

Plans have been involved in extensive provider outreach programs designed to help their trading partners better understand both the requirements and the tasks required to reach compliance. The following shighlighting these actions.

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- In May 2003, the Association announced the introduction of a ***HIPAA Transaction and Code Sets Toolkit.*** The toolkit was designed as a resource for professional providers in order to better understand the new HIPAA transactions and code requirements and promote compliance. The document was commissioned by BCBSA and written by Margaret Amatoyakulmake with Boundary Information Group. BCBSA sent the document to all member Plans to make available to their providers at no cost. The toolkit is available on the BCBSA website as well as those of our member Plans. Several provider associations are linking their website to our website to make the document available to their members.
- In 2001, BCBSA released a document entitled "HIPAA's Myths, Practical Realities and Opportunities: The Work Providers Need to Perform For Standard Transactions and Code Sets." The document was commissioned by BCBSA and produced by PricewaterhouseCoopers to dispel some of the popular myths circulating about HIPAA and shed light on the scope and magnitude of the effort providers will need to undertake to achieve compliance.
- BCBSA also worked with Tillinghast-Towers Perrin to produce a report entitled "Provider Cost of Complying and Standardized Electronic Formats" which estimated costs for providers to reach compliance with the Transactions and Codes Set regulations. We believed that without a clear understanding of projected expenditures, covered entities would not budget

sufficient financial and administrative resources to meet the requirements of HIPAA by the deadline.

- Blue Cross Blue Shield Association also developed a document for providers identifying the HIPAA Contract for each member Plan. This is also available on our website and we have made it available to numerous provider associations to post to their websites as well.
- In addition to BCBSA outreach programs, our individual Plans have implemented numerous HIPAA education and awareness programs for providers. These include conferences and workshops, dedicated provider mailings on HIPAA and individual phone calls with key electronic submitters. They have also dedicated staff and resources to industry coalition efforts. BCBSA and Plans continue to be very active and maintain leadership positions with both local and national organizations related to HIPAA such as WEDI and WEDI SNIP. We are active participants in terms of identifying, addressing, and resolving industry issues, problems and concerns related to implementation.

IV. Important lessons can be learned from implementing the initial HIPAA standards, which should be considered before additional standards are adopted.

Before any additional standards are developed and adopted, the industry should evaluate the implementation of the HIPAA regulations to date and identify ways to improve the standards process.

Over the past several years, our member Plans have identified several "lessons learned" from implementing the initial HIPAA transactions and code sets standards. The following is a brief list of issues to be considered before future national healthcare standards are adopted.

- **Credible cost benefit and industry impact analysis is required before standards are adopted.** When HHS adopted the transactions and code sets rule, the projected industry costs were greatly underestimated and savings were overstated. According to HHS analysis, a large health plan would spend approximately $1 million implementing the standard and a large hospital (100 plus beds) would spend $250,000. Consequently, entities underestimated the resources need to comply with the standard and inadequately budgeted. There were no cost estimates for Medicare or Medicaid, yet Medicaid spending alone was expected to exceed $1 billion according to an earlier estimated by the American Public Human Services Association (Association of Medicaid Directors).
- **Standards must be pilot tested before adoption.** One of the main reasons that many entities are not ready to meet the October TCS compliance date is because the industry had to wait for the publication of a critical modification to the original rule. The modification was not published until February of this year and many vendors refused to remediate their software until the final rule was published. This left little time to rework systems and test with trading

partners. It also increased unnecessary spending. Much of this could have been avoided if the original standard was pilot tested and the deficiencies or needed changes were identified and incorporated before national implementation began.

- **A concerted national education campaign is critical to the successful implementation of mandated, uniform industry standards**. Many covered entities, particularly small and rural providers still do not fully understand the requirements of T&CS. The success of administrative simplification is contingent upon all covered entities being able to send and receive HIPAA compliant transactions. An education plan is also important to dispel misconceptions about the standards. For example, many providers believed that a vendor or clearinghouse could make a covered entity HIPAA compliant. In the 2001 PWC report entitled *HIPAA's Myths Practical Realities and Opportunities: The Work Providers Need To Perform For Standard Transactions and Code Se*ts, it states:

  "regardless of whether a provider uses a clearinghouse or vendor, the provider will still need to perform a significant amount of the work, including assessing and changing business processes to collect and submit much more data than today, training staff on the new codes and modifying business operations to address the "ripple" effect of systems changes. . . This type of misinformation

dissuades providers from doing the necessary analyses to identify needed operational and contractual changes to be compliant with HIPAA T&CS."

While BCBSA widely decimated distributed the PWC report, many providers are still unaware.

V. "HIPAA II" – standards for clinical information and interoperability of health care systems is proceeding in an uncoordinated, piecemeal and inefficient fashion, which will increase spending and waste industry resources.

Over the past year, there has been a proliferation of information technology initiatives by Congress and Administration to develop national uniform standards for clinical information and the interoperability of information systems. There are many benefits that can be achieved through these proposals: reducing medical errors, improving quality, lowering health care costs and improving public health. These proposals are being pursued in addition to the numerous HIPAA financial and administrative standards the industry is currently implementing and the three pending HIPAA regulations that HHS is expected to release within the next year.

While we are very supportive of the objectives of these initiatives, these new clinical information standards are being advocated without a national strategy, prioritization or industry consensus on the direction and timeline for these

standards. As evident by the ongoing issues the industry is struggling with regarding the implementation of HIPAA T&CS, an orderly and well defined strategy is essential to a cost effective and efficient implementation of standards. These initiatives and proposals include:

- **S.1/H.R.1 Prescription Drug and Medicare Improvement Act**. A provision in the bill would require HHS to establish national standards for electronic Rx prescribing. The system envisioned would electronically connect pharmacies, doctor's offices, and health plans in real time. These systems do not exist today as envisioned by the legislation and very ambitious timelines are being contemplated.

- **H.R. 663./S.720 – Patient Safety and Quality Improvement Act**. The bill would require HHS to develop voluntary national standards for the "interoperability" of information technology systems (so the entire health care industry's computers can talk to each other in real time). Neither "interoperability" nor "health care information systems" are defined but encompass a wide range of possibilities.

- **Consolidated Health Informatics –** This Administration initiative is part of the President's e-Gov initiative. The project's goal is to adopt a portfolio of 24 data and messaging standards for the interoperability of health information

among federal agencies. These standards are needed to make electronic medical records interoperable.

- **National Health Information Infrastructure (NHII) --** This HHS initiative is to create public/private interoperable systems for electronic health records, personal health records and public health reporting.

- **ICD-10** – The National Committee on Vital and Health Statistics (NCVHS) is currently considering a recommendation to the Secretary to adopt ICD-10 CM/PCS to replace ICD-9 for diagnosis and inpatient procedure codes. It is expected that the committee will adopt a recommendation this November. Last September, BCBSA, together with American Association of Health Plans, the Health Insurance Association of American, the National Association of Medicaid Directors and the Joint Committee on Accreditation of Healthcare Organizations urged the committee to commission a cost/benefit analysis before adopting a recommendation. A report by Rand is expected to be released this week. BCBSA also commissioned Nolan to perform a cost/benefit analysis. While Nolan is only prepared to discuss preliminary results at a NCVHS hearing this afternoon, it will state that costs for hospitals, physicians, and payers are projected to be as high as $13 billion. A final report will be released in October. Nolan is still receiving stakeholder survey data that could impact these cost estimates, particularly the cost to government programs and regional hospitals. Interestingly, the report also

raises the question as to the appropriate sequence of standard adoption. For example, the author argues that in order for any benefits from ICD-10 CM/PCS to be achieved, standardization of a clinical vocabulary is a prerequisite. While this assertion needs to be validated and the impact of a national standard for clinical vocabulary analyzed, it does call into question our national strategy, or lack thereof, for information healthcare technology.

VI. The creation of a high-level stakeholder commission is urgently needed to develop a national health care information technology strategy based on industry consensus.

The current piecemeal approach to national healthcare information standards is like building a house room by room without an overall blueprint. The health care industry needs a national healthcare information technology blueprint to provide order and predictability to stakeholders and to ensure that standards are implemented in the most cost effective and efficient manner.

This blueprint should consider the consequences of the continuing demand on industry resources needed to implement the multitude of standards contemplated. While there is no comprehensive industry cost estimates of implementing Privacy and Transactions and Code Sets, it seems clear that current costs are in the tens of billions of dollars.

BCBSA recommends the creation of a stakeholder commission to reach a consensus on the goals and objectives of a national information infrastructure and to develop a comprehensive strategy for the adoption and implementation of voluntary standards. The Commission would report back to the Congress with its recommendations on a timeline, and prioritization of standards taking into account the cost, benefit and feasibility of national implementation for each standard. Congress would then develop clearly defined legislation to implement the recommendations of the Commission. We believe that a commission is essential and urges the Congress to adopt this strategy before requiring HHS to develop additional health care information standards.

Thank you for the opportunity to speak to you on this important issue. I am pleased to answer any questions Members of the Committee may have.