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Mandated Healthcare Will it Work?

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MANDATED
HEALTHCARE
WILL IT WORK?

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Dedication

The author wishes to dedicate her thesis research to her family. Who taught her about what the important things are and have supported her through all she tries to accomplish. They have also taught her that no matter what the task – if she puts her mind to it – she can complete it.

Acknowledgements

The author wishes to acknowledge the contributions of several individuals in her research study. The author expresses her appreciation and thanks to Richard Dool for his wisdom, guidance and patience. The author also wishes to thank Dr. Kuchon for her assistance and help in re-entering the program. The author is especially grateful to her family – for their encouragement and faith in her ability to complete this research project.

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Chapter 1

Introduction

Health Insurance has become a very competitive market in the United States within the past five years, often plagued by ridicule and uneasiness on what the Health Insurers are striving to accomplish. As the environment continues to evolve, Health Insurers need to meet the market's expectations while remaining compliant with State/Federal laws and mandates. One of the biggest identifiers that differentiate Health Insurers is whether the organization is Non-Profit or For-Profit. The Health Insurer, depending into which identity they fall, determines the amount of money, time and resources they have allocated to service the customer, pay claims, answer customer inquiries and change systems to meet the demands of the customers; all while complying with State and Federal mandates.

Each Health Plan is required to comply with, implement, and maintain compliance with State and Federal Legislation. It is important to understand that many of the insurers are required to implement multiple mandates while at the same time continuing to meet the customer's needs. One of the largest Federal Mandates affecting Health Insurers over the past 5 years has been around Privacy, Standardization of Information, Security and the need to share the Minimal Necessary Information based on Role and Responsibility

in servicing the patient. All of these Federal Mandates fall under the HIPAA.

Background

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996. Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. This provision falls under HIPAA Reform.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Account of 1996 (HIPAA, Title II) require the Department of Health and Senior Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nations' health care system by encouraging the widespread use of electronic data interchange in health care. Retrieved November 3, 2004 from <http://www.cms.hhs.gov/hipaa>

Among the stated goals of HIPAA is the improvement to the health insurance and healthcare industries in terms of protection of health information and cost reduction through administrative simplification. The

Security and Privacy Rules are designed to make sure that patient health information is not misused.

As more and more health information is now available in electronic format, it is critical to control access to systems and applications that contain this information. Covered Entities are required to implement technical safeguards and security measures in order to restrict access to users and patients on a need to know basis.

These technical safeguards can be very time-consuming and even ineffective if you are restricted to out of the box security provided by application or server vendors. Configuring each data repository– and individual workstation – so that they comply with the Security and Privacy Rules is not a good solution. The work effort and resources needed to support such an effort would not be cost effective or efficient and would further add to the ever growing cost of Health Care.

The HIPAA Security Rule requirements make it mandatory for Covered Entities to design and enforce effective procedures to *'ensure the confidentiality, integrity, and availability of all electronic protected information.'* Retrieved November 3, 2004 from <http://www.hhs.gov/news/facts/privacy.html>

However, designing procedures is especially difficult if the procedure

has to go into technical details. This means that technicians and security specialists must collaborate to establish it, and that the resulting rule will be obsolete once technology evolves.

Enforcing procedures is impractical if they require too many manual operations, or frequent transmission of information between many people.

For these reasons, it is definitely better to manage security procedures from a central location. If a HIPAA-mandated rule can be defined centrally and applied automatically in a matter of seconds, health information can be best protected. Of course, central administrators can choose to delegate management of some areas to local administrators.

Research Question

The purpose of the Study is to explore how HIPAA came to fruition and determine if the Health Insurers were able to meet legislated goals of improving the efficiency and effectiveness of the nations' health care system. Will the efficiencies be realized with HIPAA regulating the Federal Level Mandates while allowing States to continue Local Level Mandates?

Subsidiary Questions –

- How does the federal government communicate different stages of the process up and through implementation?
 - How are the timeframes to implement set – by what standards? If any?
 - What are the penalties that can be imposed or have been imposed?
 - What actions need to be taken for Health Insurers to implement a mandate or legislation?
 - If extensions are available – How many Health Insurers applied for extensions?
 - Are any Health Insurers still not compliant?
 - What timeframes were Health Insurers given are they all given the same timeframes?
-
- What are the industry standards times frames for mandates / legislation? Are there any?
 - What resources in the organization are used to implement these changes and are they required working on other system implementations also?

Purpose of the Study

This study will explore how mandated Health Care was introduced, what time frames are given to Health Insurers to implement these changes and were efficiencies gained post implementation. There is a growing impact to the Health Insurers and their role in not only ensuring the changes are implemented but done in a timely fashion with minimal to no impact on their day to day business.

Definition of Terms

- 1) Adequate time frames – the amount of time for mandate implementations (average medium of time calculated from the mandate implementations) using the case study with Horizon BCBSNJ and other seven Blues Plans.
- 2) Legislation/Mandate – governance from state or federal law, which requires an organization to implement or be penalized.
- 3) Protection – ensuring the customer’s information is not available to any parties but those designated or defined to have access.
- 4) Mandates – a formal order from a superior court.
- 5) Regulation - a rule or order issued by an executive authority or regulatory agency of a government and having the force of law

- 6) Legislation - the exercise of the power and function of making rules (as laws) that have the force of authority by virtue of their promulgation by an official organ of a state or other organization.
- 7) Covered Entities – synonymous to Health Insurers.
- 8) Non- Profit Health Insurer – organization established as nonprofit and does not do publicly trade stock.
- 9) For-Profit Health Insurer – a publicly traded organization.
- 10) Customer (to the Health Insurer) - one that purchases a commodity or service from a Health Insurance Organization.
- 11) Health Insurer – organization that provides Health Insurance to organizations or consumers.
- 12) Compliant – meeting the regulatory / legislative standards as imposed by the Federal Government.
- 13) Blue Cross Blue Shield Association - the trade association for the independent, locally operated Blue Cross and Blue Shield Plans.
- 14) Efficiencies – measured based on the standards set by the Federal Government.
- 15) 834 Transaction – Electronic Enrollment and Eligibility Transaction
- 16) 820 Transaction – Electronic Premium Payment Transaction
- 17) NCPDP 5.1 – Pharmacy to Pharmacy Vendor Transaction

- 18) 837 (I, P, D) Transaction – Electronic Claim Submission for Institutional, Professional and Dental Claims.
- 19) 835 Transaction – Remittance Advice Transaction
- 20) MEDA – transaction to the Medicare systems for inquiries and eligibility
- 21) 270 / 271 Transaction – Electronic Inquiry, Eligibility and associated response.
- 22) WEDI – Workgroup for electronic data interchange
- 23) SNIP – Workgroups under WEDI for strategic implementation
- 24) HHS – United States Department of Health and Human Services
- 25) AHA – American Hospital Association
- 26) EDI – Electronic Data Interchange / Interface (used interchangeably)

Limitations

This study is limited to the time period in which HIPAA has been in effect. This time period is short and does not contain a large amount of post implementation data. The study will be limited to Health Insurers servicing customers within the United States. Additionally all of the HIPAA legislation is not completed and new mandates will be imposed over the next few years. These will be excluded from this research paper. The research

paper will additionally limit the scope of the interviews will be limited only to Blue Cross Blue Shield Association plans in seven different states. These states included New Jersey, North Carolina, Florida, Illinois, Texas, New Mexico and Louisiana. The Health Insurers in the interview are all non-profit organizations; no interviews will be done with for-profit insurers.

The Health Information Portability and Accountability Act (HIPAA) of 1996 has mandated the Department of Health and Human Services (DHHS) to publish a set of rules. The Privacy Rule was published on August 14th 2002 and the Federal Register published the Security Rule on February 20th 2003. Covered Entities were expected to comply with the Privacy rule by April 14th 2003.

The Health Industry is currently preparing for implementation of the Security Rule. According to the official final rule, "Covered Entities, with the exception of the small health plans, must comply with the requirements of this final rule by April 21, 2005. Small health plans must comply with the requirements of this final rule by April 21, 2006." Retrieved November 3, 2004 from <http://www.hhs.gov/news/facts/privacy.html>.

The deadline for compliance with the Security Rule is therefore fast approaching. By April 2005, most Covered Entities (CE) will be required to comply with this rule. However, a recent study showed that as of January

2004, over 50% of Covered Entities responded they would not be compliant until 2005.

HIPAA Administrative Simplification Compliance Deadlines

Date	Deadline
October 15, 2002	Deadline to submit a compliance extension form for Electronic Health Care Transactions and Code Sets.
October 16, 2002	Electronic Health Care Transactions and Code Sets - all covered entities except those who filed for an extension and are not a small health plan.
April 14, 2003	Privacy - all covered entities except small health plans.
April 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities must have started software and systems testing.
October 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities who filed for an extension and small health plans.
October 16, 2003	Medicare will only accept paper claims under limited circumstances.
April 14, 2004	Privacy - small health plans.
July 30, 2004	Employer Identifier Standard - all covered entities except small health plans.
April 20, 2005	Security Standards - all covered entities except small health plans.
August 1, 2005	Employer Identifier Standard - small health plans.
April 20, 2006	Security Standards – small health plans.
May 23, 2007	National Provider Identifier - all covered entities except small health plans
May 23, 2008	National Provider Identifier - small health plans

Note – table documented from (US Healthcare Industry Quarterly HIPAA Compliance Survey Results)

Chapter Two

Introduction

A review of Federal and State mandates will be used as comparative tools for communication of legislation, time frames, exclusions and meeting designated delivery dates. Health Insurers must know their customers needs as well as adhere to state / federal mandates closely. Never before has understanding the importance of the market, consumer needs, legislation and regulation been so essential of the success of an organization.

In 1996, Congress and President Clinton enacted legislation that requires health insurance companies to provide -- and requires consumers to buy -- certain health benefits. These mandated benefits were hailed as a "consensus" approach to health care reform. Today, a number of additional health benefit mandates are being proposed. This section discusses how mandated benefits could do more harm than good.

At the state and federal levels, mandated health benefits have been offered as a moderate, piecemeal approach to correcting problems in our health care system. Mandated benefits require health insurance companies to provide, and force consumers to buy, particular types of coverage. These can be coverage for certain treatments (such as mammography screening), for certain providers (such as acupuncturists or dentists), or for certain

individuals (such as dependents). At first glance, health benefit mandates are very attractive, because they require insurance companies to expand health coverage.

They do, however, take away from consumers the option of not buying the mandated coverage. Consumers are forced to buy the mandated coverage -- whether they need it or not -- and therefore must often go without other coverage they need more. Thus, mandated benefits increase the cost of insurance, making it too expensive for some. (Gabel and Jensen, 1992)

Mandated Benefits and Consumer Choice

Proponents of mandated benefits argue that unless insurance companies and managed care providers are required to expand coverage for certain medical expenses, patients will suffer. Certainly, no one wants patients to have less coverage than they need. However, mandates do not give patients the coverage they demand. Instead, mandated benefits impose the preferences of politicians and interest groups on consumers.

Mandates often come about as the result of intense political lobbying by groups who want insurance companies to expand coverage for a particular type of health care. These interest groups are well-meaning, and

all lobby for care that would benefit some consumers. However, not all consumers need the type of care mandated. In reality, mandates force consumers to pay for coverage that lobbyists and politicians want them to have, but that they may not want or need.

As a result, mandated benefits tie the hands of consumers and unions by preventing them from buying other coverage that better suits their needs. A union that goes on strike for more benefits would see some or all of the negotiated benefit increase soaked up by the cost of a mandated health benefit. By mandating benefits, Congress, rather than management or labor, decides what benefits employees will receive. (Gruber, 1994)

While additional health insurance may be desirable, the decision to buy it should be made by consumers, either on an individual basis or by their representatives through collective bargaining. Consumers know their own needs better than lobbyists, lawmakers or bureaucrats. Forcing mandated benefits on unions and consumers restricts consumer choice and violates the collective bargaining process.

The Explosion in Mandated Health Benefits

To date, the federal government has enacted only a handful of mandated health benefits. The mandated benefits enacted by the 104th

Congress include mental health parity, minimum maternity stays, guaranteed issue, and portability. (Employee Benefits Research Institute, pg 13)

In contrast to the federal government, state governments have a wealth of experience in seeking out and implementing new health benefit mandates.

The same year the 104th Congress mandated minimum coverage for maternity stays, 25 states took action on the same issue, bringing to 30 the number of states that have mandated this benefit.

Similarly, by the time Congress mandated parity for mental health coverage, six states had already enacted mental health parity legislation, 32 states had already mandated mental health coverage, 15 states already mandated coverage for psychiatric nurse care, 13 states had mandated coverage for professional counselors' services, and 41 states had mandated coverage for psychologist visits.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; also known as the Kennedy-Kassebaum Act, now Public Law 104-191) requires insurers to guarantee renewal of all group health insurance plans. At the time of passage, 43 states had already enacted legislation mandating guaranteed renewal of coverage. The act also requires small group insurers to guarantee issue of all health plans. Thirty-seven states have already mandated guaranteed issue of some or all small group plans. In the

individual market, 14 states have already mandated guaranteed issue.

In fact, the last twenty years have seen an explosion in the number of health benefits mandated by state governments. All fifty states and the District of Columbia impose some health coverage mandates on consumers. In 1967, only 18 mandated benefits laws had been enacted at the state level. By 1997, state level mandates numbered 863. (Laudicina, 1996)

The most commonly mandated benefits are coverage for mammography screening (46 states), alcoholism treatment (43 states), chiropractors (41 states), and psychologists (41 states). Fourteen states require consumers to buy coverage for osteopaths, who practice a type of alternative medicine. Alaska and Washington require consumers to buy coverage for naturopaths, practitioners of another type of alternative medicine. Minnesota requires consumers to buy hair transplant coverage.

The Cost of Mandated Benefits

When government requires consumers to buy additional benefits, consumers are the ones who must pay the additional cost of those benefits. With each additional mandated benefit, the cost of health insurance goes up. As a study conducted by the Wisconsin Office of the Commissioner of Insurance attests:

Almost any benefit added to a health insurance policy increases the cost of that policy. Only those benefits that clearly serve as substitutes for more costly services or treatment actually would decrease costs. (Krohm & Grossman 1990)

Some mandates are more costly than others. The most expensive mandates are typically those that force consumers to buy coverage for care related to alcoholism, drug abuse, and mental illness. Very few mandated benefits ever reduce the cost of health insurance, largely because cost-cutting benefits do not need to be mandated. Insurance companies face financial incentives to include such coverage in their health plans, for they reduce the price of insurance and make their plans more attractive to consumers.

Increased costs lead to another negative effect of mandated benefits: greater numbers of uninsured. Businesses who can barely afford to provide health insurance and consumers at the margins (consumers who are young and healthy or less affluent) find it more difficult or less worthwhile to buy health insurance when prices increase. Consumers in the individual market are already hit with a hefty tax penalty for purchasing health insurance themselves, instead of through an employer. This market, which serves a large number of farmers and construction workers, (U.S. General

Accounting Office, 1996) will be further crippled by the cost of mandated benefits. As a result, they will drop out of the market, and increase the number of Americans without health insurance.

One measure of the cost of a mandated benefit is the cost of claims covered under that benefit. Numerous studies have concluded that depending on the number and nature of mandated benefits, they represent a large percentage of claims made against a health plan. As a result, a large portion of health insurance premiums is attributable to mandated benefits. In Maryland, which imposes more mandates on consumers than any other state, claims due to mandated benefits account for one-fifth of the cost of all claims. States with fewer mandates see a smaller portion of claims costs go toward mandated benefits. Retrieved November 3, 2004 from http://www.freedomworks.org/informed/issues_template.php?issue_id=538&isitsearch=1&search1=issue.

Chapter 3

Design Of the Study

Through this study the author hopes to determine what the Health Insurance Industry must do to effectively and efficiently implement Government Legislated requirements – specifically what Health Insurers must do to implement HIPAA legislation. The author will focus on Health Insurers who are Non-Profit and part of the Blue Cross Blue Shield Association. The author feels that by talking to these Health Insurers, she will be able to gain a better understanding of what the other Health Insurers in other states do to implement HIPAA legislation. She feels that the other Health Insurers will offer a perspective on the implementation phases, their roles in the implementation phases and efforts involved in these phases.

In addition – the author analyzes (a) their familiarity with current initiatives for HIPAA legislation; (b) their past involvement in HIPAA legislation implementation within their current organization or any past organization; (c) the perceived obstacles of implementing these initiatives; (d) what, if any, strategies they feel could assist them in future implementations; (e) cost of implementation; (f) were cost reductions realized.

The author will conduct a three tier analysis of data. The first level will include a case study of a Health Care Organization in New Jersey (Horizon Blue Cross Blue Shield of New Jersey). The case study will focus on the organizations' project plans and ability to implement HIPAA requirements, the amount the organization had to implement, the actual amount of time and resources used to implement the Mandates, were extensions filed for, what caused the extensions to be filed and what efficiencies have been released to date if any. The author will also examine what other State Mandates were required during the same time period. If the State Mandates were in line with the Federal Mandates and what resources were used to implement those required changes, was there overlap in the process and resources and were timelines met.

The author will then focus on interviewing seven Blue Cross Blue Shield Plans regarding implementation of HIPAA mandates in their organizations, the resources used, if time lines were met, if not were extensions were filed and what State Mandates were required during the same time period. The focus will be on technology, resources, time and effort.

Lastly the author will focus on articles and government documentation available around HIPAA and what has been implemented

and what has not. How was the HIPAA timeline determined and were the Health Insurers involved able to meet the required timelines and if not – what percent of the total population asked for extension and what were the reasons behind the extensions. The author will also try to determine through the literature review whether the Federal Government has seen any conflicts between HIPAA and State Mandates requirements.

By reviewing the information on these three levels the author will attempt to gain a well round picture of what the overall experience of HIPAA has been and if there are any opposing views as to the effectiveness and efficiencies of Mandated Health Care as introduced to include this information as well.

The author was going to attempt to survey other Health Insurers but in looking at the population of the validity of survey - - in this instance surveys although a good tool in gathering information; were not the optimum tool to use because there are only a hand full of major players in the industry and the number of surveys that could be sent out was a small number and taking into consideration that only a percent of the total would be returned—the author would not have a true valid sample to work with.

The author will contact the other seven Blue Cross Blue Shield Plans in January 2005 to start the interview process. The author will also attempt

to interview several different people within each organization the goal would be:

- 1) Information Technology resources
- 2) Service Resources (working in the customer service department)
- 3) Healthcare Management Resource (working in the Provider Relations department)
- 4) Sales Resources
- 5) Legal Resources (Privacy Officer or Privacy Office)

By interviewing each of these stated resources the author will attempt to put together a full picture of the organization and how the Mandates processes affected different areas of the organization.

Challenges

The author will need to ensure enough time to speak to each of the resources and ensure that the resource is not only familiar with HIPAA and the State Mandates, but was intimately involved with the work effort behind the implementation of these. The challenge will be finding these resources since many organizations hired consultants to assist with identifying work effort, resources and time schedules for HIPAA.

Data will be gathered in the case study and through the interview process with each of the identified organizations. The data gathered during the interview process will be placed into categories and analyzed by category –

1) Time

2) Cost

3) Resource

The sum of the above three categories being equated to effort. The comparison of effort and cost across all organization and the ability for the organization to meet the HIPAA timeline vs. the number of organization requesting extensions.

The information will be presented in table and graph format allowing the user to visualize the cost and effort to implement, within timelines in comparison to cost and effort to implement with extensions.

It will be important to note that the author will attempt to show a clear picture of the cost savings associated to delivering on time vs. applying for an extension but that most organizations need to apply for an extension because HIPAA guidelines were not clearly defined and with the additional work of State Mandates – the Health Insurers could not possibly meet the required timelines.

Chapter4

Analysis of Study

The Blue Cross Blue Association is comprised of over 53 organizations dedicated to improving health care in the United States by accelerating the adoption of information technology including: hospitals and clinics; medical and dental practices; professional societies and nonprofit associations; national, state and local health agencies; health plans; healthcare and IT consulting firms and vendors; health education and training providers; and pharmaceutical and research organizations.

To assist in Government mandated implementations each Plan created a HIPAA Implementation Workgroup which was initiated with the objective of - developing an overall strategy for implementing HIPAA Administrative Simplification provisions in the most efficient and effective manner possible.

In each perspective plan - The HIPAA Implementation Workgroups established work groups that involved several individuals:

- 1 Transactions, Code Sets and Identifiers
- 2 Privacy
- 3 Security
- 4 Privacy and Security Officials
- 5 Awareness, Education, and Training

Blue Cross Blue Shield Plans that Participated in the Interview Process

Across the plans, the Transactions, Code Sets and Identifiers Work
Groups met for 50 months and approximately 5,000 person-hours were spent in the transactions collaborative effort alone.
Interviews were conducted with members in each of the seven Blue Cross Blue Shield Plans on the status of their HIPAA implementation

efforts. Specific areas of the plans that were interviewed included– systems, service, sales, health care management and legal representation. Each plan was asked several questions and subsidiary questions to gather data and information regarding their specific HIPAA implementations. The Plans interviewed:

Blue Cross Blue Shield Plans that Participated in the Interview Process:

BCBS of Florida	Health Plan One	Total participants = 7
BCBS of North Carolina	Health Plan Two	Total participants = 8
HCSC (Illinois, Texas, New Mexico)	Health Plan Three	Total participants = 7 Note –This includes total of three plans
BCBS of Louisiana	Health Plan Four	Total participants = 4
Horizon BCBS of New Jersey	Health Plan Five	Total participants = 7

ing There are questions regarding what readiness really means and there seems to be no consistent reporting of a percentage of “compliant“ transactions. Some are reporting % of compliant formats while others are focusing on compliant content. Medicare and Medicaid (including some out of state Medicaid) seemed to be testing only to levels 1 and 2 while others are testing to level 6. Without end-to-end testing, there may be a false sense of readiness and a large number of rejected claims when providers who think they are compliant because they have tested and begin to send production runs to commercial carriers.

When asked which HIPAA standard transactions they are capable of conducting, 100% said they can conduct claims, 71% can do eligibility inquiry response, 64% can do remittance advice, 43% can do claims status inquiry response, and 28% can handle referral certification & prior authorization and coordination of benefits.

HIPAA TRANSACTION PERFORMED

Auth/Referral &
Coordination of
Benefits - 28%

Claims Status Inquiry -
100%

■ Claims Status Inquiry -
100%

■ Eligibility - 71%

□ Remittance Advice -
64%

□ Claims Status Inquiry -
43%

64%

Eligibility - 71%

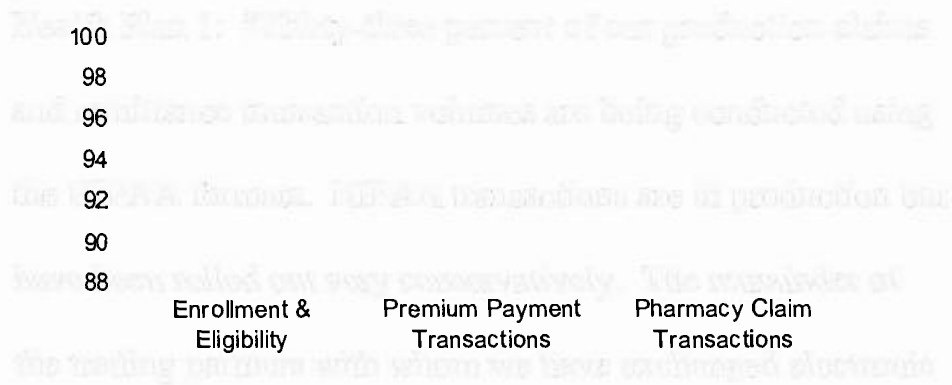
■ Auth/Referral &
Coordination of Benefits
-28%

However, when asked what percentage of their transactions are being done using the standards, six out of eight said none or only a small amount; one provider is receiving 33% claims and 33% remittance, and the other sends their claims to a vendor to be made compliant.

Of the seven plans, **one** is processing 100% of the Enrollment / Eligibility and Premium Payment transactions along with 92% of Pharmacy claim transactions; another was receiving 9.5% of the Claim Inquiry transactions, other plans continue to gather data around what transactions are used most often again finding large discrepancies on how or what the definition of 'compliance' is and how it should be measured.

factors was no adverse impact on cash flow and that they have confidence the system will handle them properly.

How many of the HIPAA transactions have been completed?



One of the largest struggles around HIPAA transactions and implementation of these transactions was based on early negative experiences with submission of HIPAA-standard claims. Most sent small batches to see what happened and planned to gradually increase as they saw there was no adverse impact on cash flow and that they have confidence the system will handle them properly.

How many of the HIPAA transactions have been completed?

Health Plan 1: “Thirty-three percent of our production claims and remittance transaction volumes are being conducted using the HIPAA formats. HIPAA transactions are in production but have been rolled out very conservatively. The remainder of the trading partners with whom we have exchanged electronic transactions in the past are still in testing. One trading partner (25% of current electronic trading partners) is in testing for

remittance. Two trading partners (66% of electronic) are in testing for eligibility.”

Health Plan 2: “We submitted 10 days approx 15M in early September to the Medicare Part A Fiscal Agent. Claims never arrived in the Medicare Processing Facility. The Electronic Data Interchange support line indicated they did not know what was wrong and we would have to wait for a call back from level 2 support. They indicated that with the volume of calls coming in it could be four business days before the call back occurred. They also would not provide escalation options other than "wait for a call back". We assumed on our end that our successful test indicated that the partner could process the claim at that time but we had failures after our go live date. They did not see us as a documented problem in the system, did not see our claims in the system and were unable to guarantee us the claims would arrive before Fiscal Year end. The resulting decision was to revert from HIPAA compliant Claim Submission for Institutional claims to the previous format occurred because of this situation. All claims were resubmitted. Cash flow was negatively affected because adjudication and payments on \$15M in claims was

delayed for ten days.”

Health Plan 3: “We were told by one of our partners that had completed testing and should begin sending full production of the Claim Submission transactions. After two weeks worth of claims (\$58M) were in the pipeline, we were informed that they could not be processed and had to be re-submitted in legacy format. This made us very nervous about committing so strongly to full production again.”

Health Plan 4: “We are currently submitting less than 10% of our claims in the new HIPAA format”

Health Plan 5: “We are currently submitting non-standard transactions, but functionality to produce standard Claim submission transactions had been moved into our clearinghouse production environment, with the standard transaction switch ‘disabled’. Waiting on many sample test Remittance Advice files to complete necessary data mapping into core Account Receivable systems. We continued to work with payers & our clearinghouse to submit standard Claim

When Submission transaction (per payer) where we continue to monitor the volumes and support the necessary transactions

For providers, health plans and vendors, the biggest obstacles they faced in moving to standard transactions was the lack of readiness of their trading partners and problems in testing with their trading partners. The lack of readiness primarily was seen as a result of the payers' and providers' dependence on vendors. A major factor is the lack of education, enforcement, or penalties for vendors. Most vendors have dependencies on other vendors. As a result of the complexity of this chain of vendors and the resulting dependencies, the national implementation effort was much more difficult than most envisioned and was painfully apparent at the local level.

When asked what benefits they have seen in using the standard transactions, 9 out of 12 responded "none." The benefits identified by the remaining three were the ease of adding trading partners, faster response times, more product stability, smaller support costs, better information capabilities and fewer user errors.

What obstacles did you face during your implementations?

Did you file for extensions?

Health Plan 1: "Some of the obstacles were: not enough money

and staff to complete the work by the deadline; lack of quick definitive answers to questions concerning implementation guides and trading partner issues; delayed or no response from trading partners due to overwhelming workload, trading partner not ready to test same transactions at same time; for the Remittance Advice, claim adjustment reason codes and remark codes are less helpful than current proprietary codes – providers had to do more follow-up work and learn new set of codes. Some payers still do not have all transactions ready (our Medicare carrier could not conduct the Inquiry / Eligibility and Associated response transaction). Educating our software vendors – it took a year to convince them to change their software to accommodate the situational data elements, which meant software updates came later than needed.

In the long term, as the codes were expanded, it will be a benefit to have the common claim adjustment reason codes and remark codes, as long as payers use the remark codes in addition to the reason codes. In general, the common code sets and formats reduce maintenance and specialized coding, and make it easier to bring up additional trading partners.”

Health Plan 2: “We are a typical insurer that relies on a few software vendors, several clearinghouses and a significant number of payers. Fortunately, our primary software vendor has done a very good job in preparing us for the Claim Submission for Institutions. Our other vendors have not been as responsive. Some of our clearinghouses and payers were slow in providing us the opportunity to test our transactions. Considering that the regulation mandated that we be ready to utilize the new transactions formats by October 16, 2002, we filed for extensions since we would go over months beyond this date.”

Health Plan 3: “Performing a Claim Submissions for Professional and Institutional claims gap analysis across five different billing systems accurate and consistent interpretation of the Situational Data Elements (SDEs) between clearinghouses, CMS & payers. Availability & coordination of internal & external testing resources (technology & people). Coordination of reports returned to entities (i.e. directly to our health system) vs. those returned to payers & clearinghouses.

Many times the same test file generated different errors across several different systems.”

It was clear that most providers would not commit to HIPAA-compliant transactions until they have confidence that they will be processed properly or were forced to move because contingency plans end. There is a significant concern that many providers will suffer cash flow because of the dependence on vendors and through no fault of their own.

When were you finally ready to move to HIPAA compliant transactions?

Health Plan 1: “We only fully migrated to the Claim

Submission transaction only when we are satisfied that the

claims would be paid at the same level as before. Initially, 3-5

days of claims were sent. Once the issues were uncovered by

reviewing the remittance were worked out, another small

production run was sent, and this process was repeated until all

the problems were worked out. It was probably be March 2004

for claims. For the Remittance Advice, the current trading

partners were to be migrated by the end of May (one payer did

not have the Remittance Advice ready at all, others had issues

that prevented migration such as missing data). There were also many internal changes to switch to the new rejection codes. For the Enrollment Inquiry/Eligibility and Associated Response, migration completion was unknown, because our Medicare carrier had not given a date of when it would be available. Even though we could migrate for another payer, we would have needed to continue to use the old format as long as it is available, because another payer would return less information on the Eligibility inquiry initially. Claim status was postponed indefinitely– since we didn't have the resources to work on it currently.”

Health Plan 2: ”Since we depended on other organizations to achieve this, we couldn't predict this with any certainty. As of December 15, 2003, we were beginning the process of testing complete transactions with Medicare, Medicaid and other Insurers. The question was – were all of the payers ready because lack of accurate communications which was making it difficult to ascertain their status? ”

When asked what percentages of customers were using their HIPAA compliant products, one vendor said 95% and the other less than 25%. Health Insurers are spending a great deal of time educating their clients on HIPAA, and smaller sites were usually less informed about HIPAA than larger sites.

Cooperation between providers, clearinghouses, and payers such as Blue Cross Blue Shield in the context of the HIPAA Transactions over the past several months has facilitated this transition. A spirit of trust and goodwill has emerged from these efforts sustained over time. . The Transactions, Code Sets and Identifiers Work Group stated, “Using the group to facilitate such collaborations has been crucial to the progress in moving the entire health care community toward compliance together.”

What was learned from these implementations?

Health Plan 1: “Some payers implemented a strategy that appears to be helpful – ranking their current submitters of electronic transactions by volume. Working down the list contacting those that have not migrated to resolve the issues preventing migration. Establish a reasonable switchover date based on the discussion. Once the larger submitters were migrated, the payers would have more time to work with the

smaller ones that would need more help and guidance. We also needed a better process to get definitive answers to disagreements about rule and implementation guide interpretations, and to get those answers available to everyone in an easy-to-retrieve format. More staff was needed at the CMS HIPAA office and at Medicare contractors who handled questions and work on issues - the wait time was very long.

Health Plan 2: “Everyone appeared to be waiting on someone else. Since recent implementation of the payer contingency plans, which permitted the industry to continue utilizing the legacy, formats, most covered entities had chosen to continue business in the same manner as they did in the past. For many, there are no pressing reasons for them to invest the necessary resources to move forward.

Without some form of enforcement, this transition period may have continued for a long time. This would mean that the industry would not be able to realize the projected benefits for implementation of the HIPAA transactions. We continued to

believe that the projected benefits could eventually be realized. Therefore, we recommended that the Health & Human Services in concert with industry organizations, such as, Workgroup for Electronic Data Interchange, the American Hospital Association and other prominent national healthcare organizations, along with their state counterparts, continued to press forward with this important project.

Each of these important organizations could have continued with even more aggressive outreach efforts to convince all related organizations that it's in everyone's best interests to achieve compliance. For example, some payers had been actively contacting their providers and providing enhanced support in moving them to the new transactions. For those providers that had chosen to lag behind, they might have been encouraged to move forward once they saw their cash flow impacted. As major payers achieved success with moving their customers to the new transactions, this would allow HHS and the major payers to be more proactive in getting all payers and their customers on board. Once the industry began to gain momentum, there will be a snowball effect that would have

allowed us to achieve our objectives.

Members expressed concern about a lack of code sets and new data elements that had not been collected in the past. Lack of an ability to test data content with all payers was a concern since Medicare and Medicaid were only testing to level two.

We were not sure that enough effort had been placed on content testing.

What additional obstacles were determined during the process?

Health Plan 1: “Additional claim adjustment reason codes and remark codes were needed. There are several data elements that providers had not gathered in the past caused problems – subscriber date of birth and sex when the subscriber was not the patient. Future guides would be making it situational. Until then, established common values that could be plugged when they were not known. Sometimes, situational notes were not enough to know as when to send certain elements (for example: dialysis-related). Providers needed to be made aware of how important it was to participate in standard

transaction formats and to review the implementation guides before they become adopted as HIPAA guides. Focus groups (including all types of providers) that could be polled for input on important changes might have been helpful, since smaller providers did not have the expertise or money to participate directly in the standard transaction format reviews.”

What was helpful, were additional extensions filed and what efforts were being made?

Health Plan 2: “At this point it’s difficult to address this area. We have been working diligently to create valid HIPAA transactions with compliant data content. Based on our testing we were optimistic that data content would not be a major issue. However, until we had tested more thoroughly with our payers and actually move into production with additional payers, we didn’t really know if we had data content concerns.”

It is clear that the contingency plan prevented a major cash crisis in the industry. The CMS roundtables and community meetings to share experiences and plans were extremely helpful in getting everyone on the same page.

What was helpful, were additional extensions filed and what efforts were being made to meet other deliverables?

Health Plan 1: “CMS roundtables and other educational

outreach by CMS and contractors, the year extension, and the contingency plan. Without the contingency plan, it would have been a disaster.”

Health Plan 2: “CONTINGENCY PLAN!!!!!!
Roundtables & Publishing of Guidance(s).“

Many responded that the implementation would have gone much smoother if they had begun testing with their trading partners sooner.

What were some of the important lessons learned? What could be done better the next go around?

Health Plan 1: “Implement fewer transactions at a time; establish 3 deadlines – set earlier deadlines for payers and clearing houses to be ready for trading partner testing, the second one for providers to be ready to test with trading partners, and then the final deadline for everyone to be migrated. There was an attempt to do this with the April testing deadline, but it didn’t work because the payers had to be ready with too many transactions at once and it didn’t specify testing with trading partners. Starting educational outreach sooner was

a key component that was missed. The issue guidance on electronic submission of Medicare claims earlier – there was no time given to do the work to comply even in the second round.”

Health Plan 2: “Participated in more beta testing arrangements w/payers. Began gap analysis earlier. It would have helped if our trading partners had published companion guides & sample test plans earlier, had more educational outreach, published contingency plans earlier, allowed for end-to-end testing, incorporating not only HIPAA edits but business edits as part of the ‘certification’ process.”

Health Plan 3: “From a broader perspective (hindsight is 20/20), group similar Electronic Data Integration transactions compliance together for go-live as opposed to trying to mandate all transactions go-live at the same time; for example, require Enrollment/Eligibility and Associated Response and the Remittance Advice and Claim Submission compliance in one year, followed by other ‘logical’ Electronic Data Integration groupings over the next set of years. Offer the contingency plan option earlier in 2003.”

The group discussed the possibility of including health care software vendors as Covered Entities. One of the primary struggles insurers had experienced is the readiness and responsiveness of vendors that support daily health care operations. Since vendors are not Covered Entities, there is no real threat to a vendor for not complying with the regulations to meet their client needs. Of course there is the threat of loss of business, however, switching vendors at that point would have resulted in a disruption to services and proven to be very costly. By including vendors as a Covered Entity, some insurers feel that entire health care industry would be represented with equal responsibility.”

What would you do differently?

Health Plan 4: “More provider involvement early on, not too many changes at once, a period of no major changes to give this implementation a chance to settle in. Resources have been stretched thin over the past few years and internally needed projects/mandates had been neglected because of HIPAA. More major changes too soon and too quickly would put a severe strain on the health care industry.”

Health Plan 5: “I think the availability of testing services

provided by consultants and other companies were very important to this project. These services will continue to prove to be very beneficial in the future.

As an insurer we have simply been working to understand the regulations and achieve compliance. We haven't spent much time trying to determine how things should have been done. We do believe, however, that we could be more successful with future implementations if we could find a way that will result in the payers, clearinghouses and software vendors being more responsive to the testing needs. This will certainly be quite a challenge but that a concerted effort by those that have been involved with HIPAA for some time could definitely make improvements in this area.

All in all it was felt that the government should have started its education efforts much earlier: the roundtable calls, website FAQs, and other guidance. The contingency plan option was very helpful but should have been offered earlier in 2003. A number of providers think the payers should have been given an earlier compliance date, allowing providers, vendors and clearinghouses more time to perform testing. Cost, time, staff and other

work efforts were a constraint across all groups - including covered entities, providers, payers, vendors etc. Although in the long term the HIPAA mandates may prove the cost effectiveness and efficiencies they set out to do - what was the current over all cost and will that truly be realized and since we still have a few HIPAA mandates - what lessons learned could we apply now?

Chapter 5

Conclusions, Recommendations, and Future Study

At the start of her research study, the author sought to explore the impact of HIPAA mandates and the influence on effective and efficient health care believing she would prove that the government had not given adequate notice/time frames for achieve the mandate dates affecting cost of Health Insurance overall. Through a comprehensive review of relevant literature related to HIPAA mandates and the direct interviews with pre-determined Health insurers, the author learned several insights into the impact of Mandated Health Care on the Health Industry and a greater understanding of an overall need to educate all associated entities as it relates to Health Care.

Both the data and literature reveal that the government's intentions and actual results could have been better defined. Both the data and literature also exposes that one of the major delays in HIPAA implementation was around the time it took the insurers to interpret the law while implementing multiple mandates at the same time. The second entity appears to be having different governed rules applied to entities supporting

the Health Insurers affecting their ability to deliver in a timely basis.

In addition, the author showed that it was necessary to consider not only the insurers, but also health care provider, payers and vendors in the whole of Health Insurance provision. The data and literature provides evidence to show that these efforts show a potential for cost effectiveness and efficiencies as applied to certain mandates - yet still seek for better government definition and control.

Healthcare and related organizations have just over two weeks to meet new rules for protecting patient data or face possible fines, criminal penalties and negative publicity. While many IT professionals involved with the Health Insurance Portability and Accountability Act compliance say that they will meet the April 20th deadline, some warn that determining compliance anything but clear-cut.

“It not like after April 20th we can breathe a big sigh of relief and forget about HIPAA compliance. That’s when we have to start proving ourselves,” says Doug Torre, director of networking and technical services at Catholic Health System, an integrated healthcare delivery network in and around Buffalo, N.Y. <http://www.nwfusion.com/news/2005/040405-hipaa.html>

An AMR Research study found that among the 225 companies that participated, some \$3.7 billion will be spent this year on HIPAA compliance (one-third of the companies will fund it through general IT budgets). In another study, though, from healthcare information management firm Phoenix Health Systems, one quarter of 318 organizations surveyed don't expect to meet the deadline for compliance with the HIPAA Security Rule.

The possible civil penalty for being in noncompliance is \$100 per violation, not to exceed \$25,000 per year for identical violations. Criminal penalties range from \$50,000 to \$250,000 on one to 10 years in prison.

“The reality of it is that HIPAA doesn't tell you how to do things – if you look at the rules, they are pretty darn gray,” says Natalie Cunningham, director of the HIPAA program office from Harvard-Pilgrim. “The rules don't say you need X or Y, so that leaves good organizations in a place where they need to make good decisions based on their business processes.”

This ambiguity can lead to problems for which an organization could be penalized.

http://www.infoworld.com/article/05/04/04/14fecompgotch_1.html

Recommendations

The primary recommendation of this study is for the HIPAA Board to solicit the advice of all affected entities of HIPAA in determining the most effective methods to reach these entities and educate them. There is a lot to be learned from these organizations. The author suggests that the organizations when contacted, educated and given enough time can be utilized effectively and could become the biggest advocates of these mandates.

The author feels that an association should be formed by all Health Insurers and supporting entities to work with the Federal Government - meeting on a regular basis - voicing concerns, status and possible workplans ensuring all are following expected guidelines. This organization would allow Health Insurers to work together without the threat of competitive knowledge and release of proprietary information being an issue.

The author feels that this organization would offer an opportunity for common entities alike to come together share information, technology and resources; allowing for a common ground of communication. This in itself would allow for a common interpretation and implementation of the law.

In addition the program would allow for easier implementations with all providers, payers and vendors since many are shared across entities. The

time period to test and implement would be decreased allowing for a quicker return on investment showing cost effectiveness and efficiencies sooner.

Finally, the organization could provide a forum to recognize groups who made or are making a difference in the Health Industry - through innovative thinking or new technology enablement.

The author would like to note that the efforts of the Blue Cross Blue Association, affiliated Blue Cross Plans, the HIPAA Committee and associated parties have a good start on what they have set out to achieve.

Although each group has a slightly different approach to reaching the goals, all need to continue to research and understand the true impact of this legislation. The entities should learn from each other and their supporting entities while trying to expand on the other's ideas as it fits into their individual plan's needs.

In closing, the author would like to reiterate how important it is for the Health Insurers and Government to reach a common ground and work together to implement these mandates and reach each implementation date successfully. The author had a very strong perception going into this study that the Health Insurers were not given ample time to implement the HIPAA mandates whereby the cost to implement these mandates were driving up the cost of Health Insurance. Although there may be some relationship between

HIPAA and health care costs, it is not the only factor and these mandates have given all parties large latitude to learn from each other but to further define and work with entities related to health care.

Future Study

The author believes that her literature review and empirical research gathered by her interviews contributed to the growing body of information related to HIPAA Mandates, Time Frames, Cost Effectiveness and Efficiencies and how they relate to Health care. However, more research is needed on this subject before definitive conclusions can be drawn about the success of these efforts. Specifically, the author recommends that research be conducted as a follow up to the implementation of strategies over the next 5 years and including the last of the HIPAA requirements due over the next two years. Most importantly the author believe that more research should be done to examine the true cost efficiencies and effectiveness of HIPAA as it exists between Health Insurers, the Insured, Providers, Payers and Vendors and how it can be improved.

Appendix A

Interview Questions

- 1_ Number of resources assigned to HIPAA mandates (full or part time basis and how many consultants were hired)
- 2_ Number of resources working on State Mandates – was there an overlap in the resource pool.
- 3_ Project plans for HIPAA and State Mandates – what were the time/efforts realized and were dates met.
- 4_ What was the dollar amount spent to implement HIPAA?
- 5_ What is the annual budget allocated for State Mandates?
- 6_ Has implementation of HIPAA made the organization more efficient?
- 7_ Were extensions filed for HIPAA implementation?
- 8_ Has HIPAA and other State Mandates had a financial impact to the organization which in turn increased premium rates?

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