

HIPAA Implementation:

The Case for a Rational Roll-Out Plan

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1. Summary

HIPAA Administrative Simplification, as it is currently being implemented, is increasing complexity and cost for health care providers and payers. Although the HIPAA “train wreck” predicted for October 2003 was averted by timely and critical CMS action by the Centers for Medicare and Medicaid Services (“CMS”), the statutory HIPAA goals of reducing administrative costs and increasing efficiency are in jeopardy. Administrative Simplification is at risk largely because providers cannot satisfy new, onerous data content burdens and the industry¹ has failed to implement HIPAA as an exchange of electronic transactions – a two-way rather than a one-way street – as required by law. HHS has the authority to take action that will bring about industry-wide success in achieving the HIPAA goals of Administrative Simplification. Without action the consequences will be costly in the immediate term and will put in jeopardy future standards envisioned by President Bush and the Department of Health and Human Services (“HHS” or “the Department”)² to be established through the National Health Information Infrastructure initiatives. We recommend that CMS:

- specify that HIPAA-compliant claims submitted by providers require only the data needed by payers for adjudication;
- coordinate a rational, industry-wide roll-out that promotes the exchange of HIPAA standard transactions as a two-way street;
- issue guidance clearly telling payers what they should do before terminating use of their contingency plans; and
- establish a HIPAA standard acknowledgement format.

2. Introducing WebMD

WebMD Envoy conducts more HIPAA transactions than any other private entity. In total, WebMD processes more than 3.0 billion transactions on an annualized basis for 300,000 physicians, hospitals, dentists, labs and pharmacies, submitting to more than 1,500 payer connections. Although fewer than 19% of the medical claims that we receive are in HIPAA format, 70% of the medical claims and 80% of all transactions going out to payers are in HIPAA format. Accordingly, WebMD plays a vital role in assisting health care trading partners to comply with the Transaction Code and Set Regulations (the “Transaction Rule”).

¹ “Industry” refers to health care providers and payers as well as software vendors and clearinghouses involved in the electronic exchange of health information.

² Exec. Order No. 13,335, Sec. 3(a)(i), 69 Fed. Reg. 24059 (April 27, 2004); Harnessing Information Technology to Improve Health Care, United States Department of Health and Human Services Fact Sheet (May 6, 2004), available at <http://www.hhs.gov/news/press/2004pres/20040427a.html>.

3. The HIPAA Promise: Administrative Simplification

As envisioned by Congress, codified by law and embraced by the industry, HIPAA Administrative Simplification would reduce administrative costs by increasing efficiency through the exchange of electronic communications between providers and payers.³ As HHS noted in the preamble to the final Transaction Rule, “The lack of standardization makes it difficult and expensive to develop and maintain software. Moreover, the lack of standardization minimizes the ability of health care providers and health plans to achieve efficiency and savings.”⁴ At the core of the HIPAA promise is the commitment to reduce administrative costs by defining standards for electronic transactions so that all participants in the electronic health care marketplace would speak the same language and use the same practices. Instead of negotiating the details of more than 400 claim forms, providers would fill out just one form that would be accepted by all payers. The information payers sent back to providers would be equally uniform. The simplicity brought about by standardization was expected to encourage more providers to switch from paper to electronic transactions.

HHS estimated that the health industry would save \$29.9 billion dollars in administrative expenses over a ten-year period beginning in 2002 as a result of Administrative Simplification.⁵ The Department “used conservative assumptions” and predicted that the benefits of standardization “will accrue almost immediately” and would exceed costs incurred by health care providers and health plans after the second year of implementation.⁶ The Department expected that implementation costs were “one-time or short-term costs related to conversion” and included in its calculation automation costs as well as costs associated with implementation problems. HHS also acknowledged that “there may be some ongoing maintenance costs” but anticipated these costs would be factored-in by vendors “as part of the purchase price.”⁷ According to HHS’s calculations, “[t]he total net savings for the period 2002-2011 will be ... \$13.1 billion for health plans, and ... \$16.7 billion for health care providers.”⁸

³ 42 U.S.C. §§ 1320d-1 *et. seq.*

⁴ 65 Fed. Reg. 50312 (August 17, 2000).

⁵ 65 Fed. Reg. 50351 (August 17, 2000).

⁶ 65 Fed. Reg. 50351 (August 17, 2000) (“Based on this analysis, the Department has determined that the benefits attributable to the implementation of administrative simplification regulations will accrue almost immediately but will not exceed costs incurred by health care providers and health plans until after the second year of implementation.”)

⁷ 65 Fed. Reg. 50351 (August 17, 2000).

⁸ 65 Fed. Reg. 50351 (August 17, 2000) (“Based on this analysis, the Department has determined that the benefits attributable to the implementation of administrative simplification regulations will accrue almost immediately but will not exceed costs incurred by health care providers and health plans until after the second year of implementation.”)

The HIPAA statute specifies that the standards adopted “shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.”⁹ Congress reiterated this objective in the statute three times,¹⁰ and the Department clearly stated that “[t]he purpose of [the Transaction Rule] is to improve the ... efficiency and effectiveness of the health care system.”¹¹ Consistent with Congress’s clear intent that Administrative Simplification reduce administrative costs, standard electronic health care communication must be implemented in a manner that is consistent with and satisfies this objective. In order to achieve the objective of HIPAA, implementation should (1) simplify commerce, (2) reduce health care costs, and (3) increase the use of electronic transactions. HIPAA Administrative Simplification addresses three aspects of standard electronic communication: transaction format, transaction data content, and transaction exchange. The way in which each aspect is implemented has implications for the objectives of Administrative Simplification.

A) Transaction Format

Transaction format is the cornerstone of, and a necessary precursor to, all other aspects of standardization. According to the Transaction Rule, “[f]ormat refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.”¹² Transaction format governs how the information contained in a transaction must be organized; for instance, the information must be written from left to right, in English. Format is the electronic equivalent of the blank spaces to be filled on the paper form. Establishing a common transaction format simplifies commerce and reduces cost by eliminating redundant data processing efforts and expenses associated with maintaining the hundreds of different proprietary claim formats in use prior to HIPAA.

B) Transaction Data Content

Transaction data content refers to the information or “data elements,” such as the patient’s name and address, carried in a transaction.¹³ The Rule defines data content as “all the data elements and code sets inherent to a transaction, and not related to the format of the transaction.”¹⁴ Standardizing data content is important for the purpose of limiting the information that may be contained in a transaction. HIPAA refers to this limitation as the “maximum defined data set.”¹⁵ As the Department noted, “the intent behind the maximum

⁹ 42 U.S.C. § 1320d-1(b).

¹⁰ See 42 U.S.C. §§ 1320d-1(b), -1(c)(2)(A)(i), -2(a)(1)(B).

¹¹ 65 Fed. Reg. at 50,312.

¹² 45 C.F.R. § 162.103.

¹³ *Data Content and Code Sets: The Devil is in the Details*, Centers for Medicare and Medicaid Services, at 1 (accessed at <http://www.cms.hhs.gov/medicaid/hipaa/admsim/vol1map4.pdf> on January 20, 2003).

¹⁴ 45 C.F.R. § 162.103.

¹⁵ 65 Fed. Reg. at 50322 (August 17, 2000).

defined data set was to set a ceiling on the nature and number of data elements inherent to each standard transaction.”¹⁶ Capping data content simplifies commerce and reduces administrative costs because collection, transmission, and storage of each additional unit of data consumes personnel and other resources.

C) Transaction Exchange

Transaction exchange is the back and forth transmission of electronic information. The legislature clearly contemplated that HIPAA would be a two-way street. Congress specified that, “[i]f a person desires to conduct a transaction... as a standard transaction... the health plan may not refuse to conduct such transaction as a standard transaction.”¹⁷ Each transaction is one part of a series of electronic communications between and among providers and payers, either directly or through clearinghouses and other intermediaries. As envisioned under the Rule, the provider would initiate the exchange by electronically asking the payer whether the patient is eligible for a particular service on a particular date. The payer would respond immediately and treatment decisions would be made by the patient and the health care provider. Care would be provided, the encounter documented, and the claim electronically submitted to the payer’s adjudication system. The payer would electronically acknowledge receipt of each claim and specifically identify and provide an explanation for any claim rejected prior to adjudication.

At any point after submission, the provider could electronically inquire about the status of the claim and receive an immediate status report. The payer would adjudicate the accepted claims and electronically remit payment along with an explanation of how much was paid or not paid to the provider for each claim. This information would be stored by the provider and could be used to submit electronic claims to secondary payers. Implementing HIPAA as a two-way street simplifies commerce and reduces administrative costs because information can be carried over from one transaction to the next, thus eliminating redundant data collection and other administrative burdens.

4. Missing the HIPAA Mark

The simplification envisioned by HIPAA has not materialized and the statutory HIPAA goals of reducing administrative costs and increasing efficiency are in jeopardy. Although the administrative “train wreck” anticipated in October 2003 with the implementation of HIPAA was averted by CMS action, Administrative Simplification remains at risk for three reasons that correlate with the three aspects of electronic communication governed by HIPAA. First, there is a lack of uniformity in application of the standards adopted under HIPAA. Second, providers cannot satisfy extended data content burdens. Third, the industry has thus far failed to implement HIPAA as a two-way street.

¹⁶ 65 Fed. Reg. at 50322.

¹⁷ 42 U.S.C. § 1320d-4(a)(1).

A) Transaction Format – Lack of Uniformity

The standards and implementation specifications are extremely complicated and thousands of pages long. Multiple versions of a HIPAA standard claim have emerged as each payer defines for itself what constitutes a “HIPAA-compliant” claim. Payers have published more than 600 different “companion documents” setting forth their individual interpretations and implementation of the government guidelines. That number is expected to grow to one thousand.¹⁸ The standards, as currently being implemented, are increasing the complexity, and therefore the costs of electronic transactions. For this reason, Administrative Simplification discourages providers from submitting electronic transactions instead of paper.

B) Transaction Content – Expense in Extended Content

As the standards are currently being implemented, additional, unnecessary, and unused information must be collected by providers but is then discarded by payers. While enforcement of the transaction content cap – or maximum defined data set – does support the HIPAA objective of increasing efficiency and reducing administrative costs, requiring extended HIPAA data content does not. Most providers cannot collect and most payers are not prepared to use full HIPAA data content. Software vendors and clearinghouses are struggling with the demands of extended data content. While some payers are able to accept transactions with extended HIPAA data content, these payers typically suppress the new content when the transaction is taken into their system for adjudication because the extended data causes incorrect rejections by the payers’ adjudication systems. Contrary to the promise envisioned by the standard, this unused data is not typically retained for use by subsequent payers.

C) Transaction Exchange – Traffic Flows Only One Way

Contrary to the requirements of the law, HIPAA communication is currently a one-way street. The Rule clearly states: “Except as otherwise provided in this part, if a covered entity conducts with another covered entity . . . using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction.”¹⁹ According to the statute, although a provider may elect to conduct a transaction as a paper transaction, a covered electronic transaction must be conducted as a standard transaction and, at the request of any person, a payer “may not refuse to conduct such transaction as a standard transaction.” Despite Congress’s explicit requirement that electronic transactions are to be a two-way electronic street, success in exchanging HIPAA formatted transactions is largely limited to submission of health care claims.

Although health care claims are widely exchanged in the HIPAA standard format, the other standard transactions lag far behind. Even Medicare – the nation’s largest payer and one of the most successful HIPAA trading partners – acknowledges that its carriers and Fiscal Intermediaries have problems conducting other covered transactions as HIPAA standard

¹⁸ Kupa Zubeldia, *HIPAA Transaction Update (and NPI Stuff)*, presented March 9, 2004 at the Eighth National HIPAA Summit, available at <http://www.ehcca.com/presentations/HIPAA8/zubeldia.pdf>

¹⁹ 45 C.F.R. § 162.923(a).

transactions. Medicare acknowledged in March 2004 that only 27% of submitters/receivers are in production for remittance advice and 7% of submitters/receivers are in production for coordination of benefits.²⁰ Medicare carriers and Fiscal Intermediaries are unable to conduct eligibility transactions and have directed trading partners not to send HIPAA eligibility inquiries. As expected, other payers are even further behind in implementation of the non-claim HIPAA transactions. Only 3.1% of the payers to which WebMD transmits claims are engaging in all of the HIPAA standard eligibility, claims status, and remittance advice transactions through WebMD.

In addition, the lack of a HIPAA standard acknowledgment is widely recognized by the industry as a barrier to implementation of Administrative Simplification. To the extent that payers acknowledge receipt of a claim at all, the format is not uniform, and therefore providers are not able to efficiently accept, process and, where necessary, respond to the information included in the acknowledgment.

The industry's singular focus on implementation of electronic claims is counterproductive. Perfection in claim transactions is not necessary to conducting other transactions. Implementation of claim format allows trading partners to use whatever information is contained in the claim to conduct other electronic transactions. The efficiencies of administrative simplification are accrued through the electronic back and forth exchange of information because information can be carried over from one transaction to the next. Claim format alone eliminates the administrative burden and expense of re-collecting and sending the data.

Implementing HIPAA as a two-way street will reduce the overall cost of health care administration but the benefits and burdens are experienced by individual payers and providers at different points in the HIPAA claim life cycle. Providers currently bear the burden of initial data collection in order to submit a claim. They experience the greatest efficiencies from real time responses to patient eligibility, health claim status inquiries, and remittance transactions. Payers, on the other hand, benefit greatly from electronic submission of claims. They avoid expensive processing of paper claims and auto-adjudication is assured through clearinghouse translation of claims.

Clearly the benefits and burdens of HIPAA implementation are not yet shared equally in the health care industry. While some payers may be reaping the benefits of electronic claims transmissions, many are not yet fulfilling their obligations with regard to other HIPAA transactions that would benefit providers. The failure to implement the return transactions, including ERA and claim status, has left many providers investing capital without significant returns and caused other providers to delay investing in electronic systems until there is evidence that the investment will pay off.

5. Getting HIPAA back on Track: HHS Leadership

²⁰ Karen Trudel, *Where Are We Now, Where Are We Going*, Address at the Eighth National HIPAA Summit 7 (Mar. 8, 2004), available at <http://www.ehcca.com/presentations/HIPAA8/trudel.pdf>.

HHS must take action to facilitate the successful implementation of Administrative Simplification. Industry efforts to implement Administrative Simplification have resulted in complex standards, expensive and inefficient implementation and uncertainty in the market place. A few strategic actions by the Department can leverage the remarkable forces and resources of the health care industry to achieve the objectives of Administrative Simplification. WebMD urges the Department to take the following steps:

- A) Specify that HIPAA-compliant claims require only the data needed for adjudication;
- B) Work with industry groups to adopt a rational, industry-wide roll-out plan that promotes the exchange of HIPAA standard transactions as a two-way street; and
- C) Continue the contingency period and issue guidance clearly telling payers what they should do before terminating use of their contingency plans.

A) Define “HIPAA standard” as limited content

We urge CMS to enforce HIPAA content requirements only as a cap on what may be contained in a covered transaction.²¹ Requiring transactions to carry extended HIPAA content is counterproductive to the cost saving goals of HIPAA. So long as payers have enough information to adjudicate the claim, and it is in HIPAA standard format, the claim should be considered HIPAA-compliant. We ask that CMS define the “HIPAA standard claim” through the immediate adoption of practical implementation specifications that make clear payers should not reject or delay claims because data that are not needed for adjudication are missing.

We suggest that CMS build upon investments already made in HIPAA standards by acknowledging that the use of default data is permissible. This will enable providers and payers to use their current HIPAA claim submission and adjudication systems more effectively and minimize the need to retool or reprogram. We recommend that CMS establish or support the establishment of a list of standard defaults that trading partners may use. This will go a long way toward standardizing data content in HIPAA transactions.

B) Coordinate industry roll-out to HIPAA as a two-way street

Implement full complement of HIPAA transactions

It is widely recognized in the industry that only through implementation of all the covered transactions will administrative efficiencies, and therefore savings, be realized. CMS has an important leadership role to play in making this HIPAA objective a reality. We recommend that, as a payer, CMS focus its implementation efforts on the complete set of HIPAA transactions. To these ends, the Medicare contingency plan should address the full set of

²¹ We have previously provided HHS with a BNA article on defining the HIPAA standard. Attached for your convenience is a copy of the article. BNA's Health Law Reporter, Vol. 12, No. 36 at 1399 (Sept. 11, 2003 pp. 1399).

transactions, not simply HIPAA formatted claims. Other payers will follow Medicare's example and diversify efforts to ensure a balanced implementation initiative that recognizes HIPAA is more than just submitting claims.

Prioritize, Phase-in, Build on Success

In addition to leading by example, we urge CMS to coordinate a rational, industry-wide roll-out to the HIPAA standards for all covered transactions. It is critical that CMS prioritize implementation of the transactions that will provide the greatest system-wide benefits. Compliance should be phased-in by covered entities based upon their role in the system – first payers, then clearinghouse/vendors, and then providers. Finally, CMS should encourage HIPAA implementation to build on initial success. Perfection in claim submissions is not required for successful exchange of other covered transactions. We urge CMS to address this publicly and encourage all payers to take steps to implement other HIPAA transactions.

Recognize the role of a two-way street in enforcement decisions

WebMD urges CMS to affirm publicly that HIPAA must be a two-way street for cost savings to be achieved and to exercise leadership and its enforcement authority to implement HIPAA accordingly. CMS has broad authority to enforce implementation of HIPAA transactions. CMS, as both a payer and the enforcer of HIPAA standards, has an obligation to apply the HIPAA standards in a fair and balanced manner. An exclusive focus on claims unfairly penalizes some trading partners while failing to provide equal support for implementation of the transactions from which those trading partners benefit. It is vital that CMS make clear that enforcement decisions will take into consideration efforts by trading partners to implement HIPAA transactions in a balanced manner that ensures two-way electronic communication between trading partners.

We ask that CMS issue industry guidance making clear that contingency planning should incorporate implementation of all HIPAA covered transactions, not just claims. The guidance should establish that not only are health plans responsible for conducting outreach to their trading partners, but this outreach must include the entire complement of HIPAA transactions. We urge CMS to include in the guidance instructions for incorporating all transactions into the contingency plan and the steps that should be taken by a payer prior to terminating use of its contingency plan for any covered transaction.

We urge CMS to adopt a HIPAA standard format for acknowledgment of transactions received by payers. This gap in the transaction set has been widely recognized by the industry and this issue has been noted in several of the implementation guides for the HIPAA transactions currently in use. Adoption of a standards acknowledgment format will prevent many of the down stream difficulties currently experienced in HIPAA implementation efforts.

C) Continue the contingency period and issue guidance on terminating use of contingency plans

Continue contingency period

Widespread use of contingency plans that allow providers to submit and payers and clearinghouses to accept claims and other transactions in non-HIPAA standard format has prevented the administrative train wreck predicted in the fall. In July 2003, the Department permitted covered entities to implement contingency plans in order “to maintain the flow of payments while continuing to work toward compliance.” CMS, through the Office of HIPAA Standards, should support the progress made by the industry to date by continuing the contingency period under which trading partners are operating contingency plans. It is important for CMS to make clear that the contingency period should be used by trading partners to transition to the HIPAA format for all covered transactions.

Define and Ensure Payer and Provider Readiness Through a Rational Roll-Out Plan

- It is critical that payers not unilaterally terminate their contingency plans and accept only HIPAA standard claims unless both payer and provider are demonstrably ready to conduct standard transactions. Converting to the HIPAA standard is like rewiring a house while the electricity is still on – steps must be taken to ensure continued flow of power while the old wire is being replaced. Unilateral termination would almost certainly cause claim processing delays and cash flow disruptions. We urge CMS to provide guidance regarding payer and provider readiness that should be achieved prior to the termination of contingency plans. The ability to accept and process a HIPAA standard claim or any other transaction is not a sufficient indicator of payer readiness.

We urge CMS to support the concept of payer readiness both as a payer and the enforcement agency for HIPAA standards. Medicare should not terminate its contingency plan or in any way penalize providers unable to submit HIPAA formatted claims until Medicare can satisfy the above measures of readiness for claims transactions. We ask that CMS be equally specific in guiding the industry toward full implementation of the other HIPAA standards. The Office of HIPAA Standards should enforce the HIPAA standards in a manner that requires payer readiness to be demonstrated prior to termination of contingency plans in place for the acceptance of claims or other transactions in non-HIPAA format.

6. Conclusion

Much progress has been made by the industry implementing the HIPAA standard format; however, much more remains to be done. CMS action is vital to ensuring that the HIPAA objectives of cost savings and increased efficiency are achieved. The success or failure of HIPAA implementation will have significant implications for the success or failure of the National Health Information Infrastructure.