

**Testimony of the  
HIPAA Implementation Working Group**

**National Committee on Vital and Health Statistics  
Subcommittee on Standards and Security Hearing  
on  
Business Impact of the Implementation of  
the HIPAA Electronic Transactions and Code Sets Standards**

**April 6-7, 2005**

**American Hospital Association  
American Medical Association  
Laboratory Corporation of America Holdings  
WebMD Envoy  
AFECHT**

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The HIPAA Implementation Working Group (“Working Group”) is an informal working group of health care providers, vendors, and clearinghouses that came together to increase provider and vendor involvement in the standard setting process. The coalition includes the American Hospital Association (“AHA”), the American Medical Association (“AMA”), the Association for Electronic Healthcare Transactions (“AFEHCT”), Laboratory Corporation of America Holdings, and WebMD. Collectively, the Working Group represents thousands of the nation’s physicians and hospitals, as well as clinical laboratories, clearinghouses and vendors. We are pleased that the National Committee on Vital and Health Statistics (“NCVHS”) is holding today’s hearing on the business impact of implementing of the HIPAA electronic transactions and code sets standards. We appreciate the opportunity to offer the comments and suggestions below on how to further the objectives of reducing costs and increasing efficiency in health care administration. Any questions about the Working Group testimony may be directed to Lawrence Hughes of the American Hospital Association at lhughes@aha.org or (202)626-2346.

At the core of HIPAA Administrative Simplification is a commitment to reducing 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, reduce costs and increase efficiency.

Significant progress has been made in implementing a standardized electronic claim form through the use of the 837 claim transaction. As 837 use becomes routine the healthcare industry has begun to discuss the implementation of standards for other transactions. Collaboration is increasing among many sectors of the industry to ensure that standards have the utility and promote the uniformity envisioned by the statute. In addition, providers and vendors are becoming more active participants in the standard setting process. The dialogue around standard setting and implementation has been extremely valuable and has allowed industry participants to identify new opportunities for cooperation and collaboration.

There is growing industry consensus that the HIPAA transaction standards as adopted have not resulted in the uniformity and efficiency that was envisioned under the statute. The Council for Affordable Quality Healthcare has established the Committee on Operating Rules for Information Exchange (“CORE”) to develop operating rules to supplement the standard eligibility transaction. These operating rules have the potential to increase the utility of the eligibility transaction by improving provider access to uniform, reliable patient-specific information. The Workgroup on Electronic Data Interchange (“WEDI”) has intensified industry dialogue about the need to have uniform mechanisms to acknowledge the receipt and processing of standard transactions. The adoption of robust standard acknowledgements to claim transactions would help eliminate provider and vendor frustration with the “black hole” of unanswered claim transactions and allow for the more efficient and productive use of the claim status transaction. Private sector efforts to address some of these issues are gaining momentum. Through the Convergence Project, the Claredi Corporation has convened industry stakeholders to review payer companion guides for the claim transaction. This effort may help reduce the payer-specific customization of standard claim transactions. Finally, the provider caucus within X12 is

growing in both size and influence. The Working Group supports these private sector initiatives to promote standardization.

Unfortunately, for providers, clearinghouses, and many others, standards implementation has yet to result in any clear return on investment. The savings predicted by the Department of Health and Human Services (“HHS”) of \$29.9 billion dollars in administrative expenses over a ten-year period beginning in 2002 are far from view. To date, the costs of complying with the Transactions and Code Sets Standards have been significant and there are no data showing that providers have experienced any return on their investment.

The benefits of adopting any transaction standard relate primarily to the ways in which standardization improves a participant’s ability to receive useful detailed information in a timely, uniform, and cost effective manner. The 837 claim transaction, which has been the primary focus for the HIPAA transition, is bringing limited, if any, benefit to the provider community in part because significant payer-specific customization is still required. As the focus of HIPAA implementation shifts to transactions through which healthcare providers can obtain useful information, the opportunity for a positive business impact from standardization grows. For example, providers expect to see direct financial benefit from timely and useful patient eligibility, remittance advice, and claim status information.

Furthermore, the degree to which standards implementation has a positive or negative business impact also depends heavily on whether the standards reflect the needs of those who use them. The current standards do not consistently address the business needs of the provider and vendor communities. This is due in part to the historically insufficient representation of providers and vendors in the standard setting process and in part due to the

limited understanding of how the standards would be used in practice. We should learn from these experiences and use them to strengthen the standard setting process.

*Divergent Requirements, Definitions, and Usage Need to be Minimized*

One clear lesson from our experience to date is that additional steps are necessary to ensure that the implementation of transaction standards provide the degree of uniformity necessary to achieve true industry standardization. Each transaction standard identifies a maximum data set and mandates a standard format for the transmission of information. However, through the issuance of companion guides and informal directives, each payer issues its own guidance on how to interpret these standards, including its own data definitions, data requirements, and business usage rules. As a result, providers and vendors must customize the information they transmit in “standard” transactions to meet the specific, and frequently conflicting, interpretations of each payer. Similarly, to the limited extent that payers conduct standard transactions to communicate information, vendors and providers must use payer-specific definitions and usage to interpret the information they receive. The degree of variation within HIPAA standards is undermining the goals of the statute to reduce administrative costs and increase efficiency in the healthcare system.

*Data Requirements Should Better Reflect Data Needs and Be Linked to Data Access*

The HIPAA implementation process would benefit significantly from a systematic assessment of the benefits and burdens associated with the required data collection. Among the criteria which should be assessed are: who endures the burden of collecting the required data element under the standard; is this the entity best situated to obtain the data element; do the benefits of collecting the data element outweigh the burden associated with the collection of the data; and to what extent is the burden of data collection offset. Making the

benefit-burden analysis an integral component of standard setting and standard modification processes would reduce the risk of ineffective, inefficient and costly assignment of responsibility for data collection.

### *Change Process Should Be Streamlined to Better Meet Industry Needs*

When there is widespread support to redress problems presented by an existing HIPAA transaction standard, the process should be timely and responsive. Under the current system, standard modifications that have been approved in the Designated Standards Maintenance Organization (“DSMO”) change process have languished for months prior to adoption. Furthermore, allowing individual standard setting organizations to override the changes approved through the DSMO process undermines the efficacy of the process for everyone.

### *What Can the Federal Government Do to Facilitate HIPAA Implementation and Promote a Return on Investment?*

#### Quantify the Cost and Benefits of HIPAA Implementation

Anecdotal evidence suggests that the projected cost savings that would result from implementing the Transactions and Code Sets Standards are far from being realized. Moreover, it appears that such estimates did not adequately account for the imbalance in return on investment across industry segments and among transaction standards. However, there is little data with which to quantify the true impact of standard implementation. A systematic analysis of the costs and benefits of standards implementation across the industry would enable a better-informed dialogue about how to promote the use of standard transactions and how to allocate resources to promote return on investment.

### Improve Standard Setting and Modification Processes

CMS is developing a proposed rule to address the current barriers to timely modification of existing HIPAA standards. While the details of the proposal have not yet been unveiled, the creation of a mechanism to streamline the process for modifying standards would benefit the entire industry. Furthermore, we would welcome the inclusion of processes in this modification system to assess the benefits and burdens of proposed modifications and to provide compensation for the imposition of burdens that do not have a corresponding benefit. The Working Group believes that the creation of an efficient standard modification mechanism would address a significant weakness in the current standard setting process.

### Continue the Contingency Plans

The adoption of the contingency plans helped avoid the administrative train wreck that may have resulted from requiring instantaneous, universal transformation of our complex system of electronic healthcare transactions. The evolutionary nature of the standards adoption process has become apparent and contingency plans continue to be vital to maintaining provider cash flow through the transition. Specifically, decisions regarding contingency plans should reflect the status of all HIPAA transactions, not merely the claim transaction. Enforcement efforts should also reflect an understanding of HIPAA implementation as a system-wide migration by participants of varying size and resources. For example, although Medicare and other large payers are receiving the vast majority of their claims in the standard format, there are hundreds of smaller payers who are still struggling with the transition.

## Develop and Help Implement a Rational Transition

CMS should coordinate the development and implementation of a rational, system-wide transition plan to advance the adoption of all of the HIPAA standard transactions. HHS can do this both by convening stakeholders and asking advisory bodies such as NCVHS to discuss and advise on a rational transition plan, and through leadership by example through Medicare and Medicaid. Key steps in the industry's HIPAA implementation process had their genesis in decisions by Medicare, including the development of the contingency plan concept, the focus on the claim transaction, and the decision to accept HIPAA format-compliant claims without requiring full data content. Having achieved system-wide implementation of the HIPAA standard format for claims, CMS should prioritize implementation of the standard transactions that will provide the greatest system-wide efficiencies.

As part of a rational transition plan, CMS should adopt a process of sequenced implementation of the remaining HIPAA standards. Specifically, CMS should phase in compliance based on the role the participant plays in the system (first payers, then clearinghouses and vendors and finally providers) and the capacity of the entity to achieve compliance (first large, then small entities). Sequenced implementation would reduce inefficiencies in the transition by allowing for methodical system development and testing within and among industry participants.

We are pleased to note that CMS has pursued demonstration projects prior to dictating a standard for claims attachments. We recommend that CMS consider whether similar demonstrations or other pilot testing for adopted HIPAA transactions standards may facilitate the evolution and therefore utilization of such standards.