Administrative Simplification History & ...

October 25, 2001
HIPAA Summit 3

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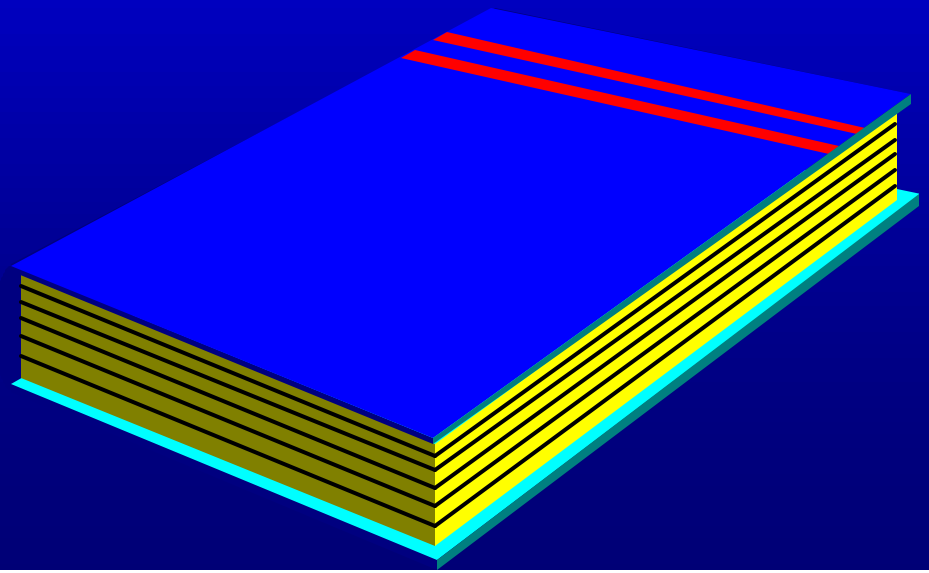
Administrative Simplification

The **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (HIPAA)

Signed into Law August 21, 1996

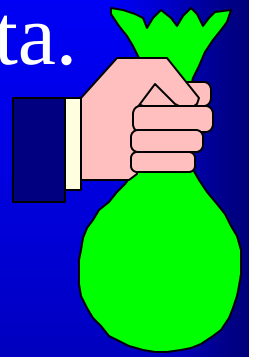
Administrative **S**implification **S**ubtitle

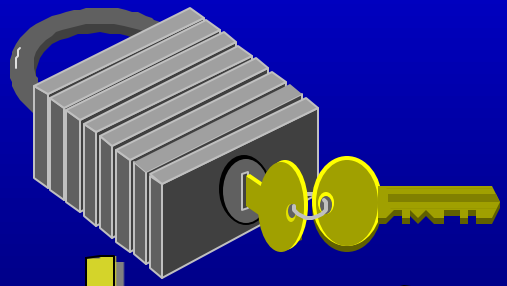


Purpose of HIPAA

Administrative Simplification

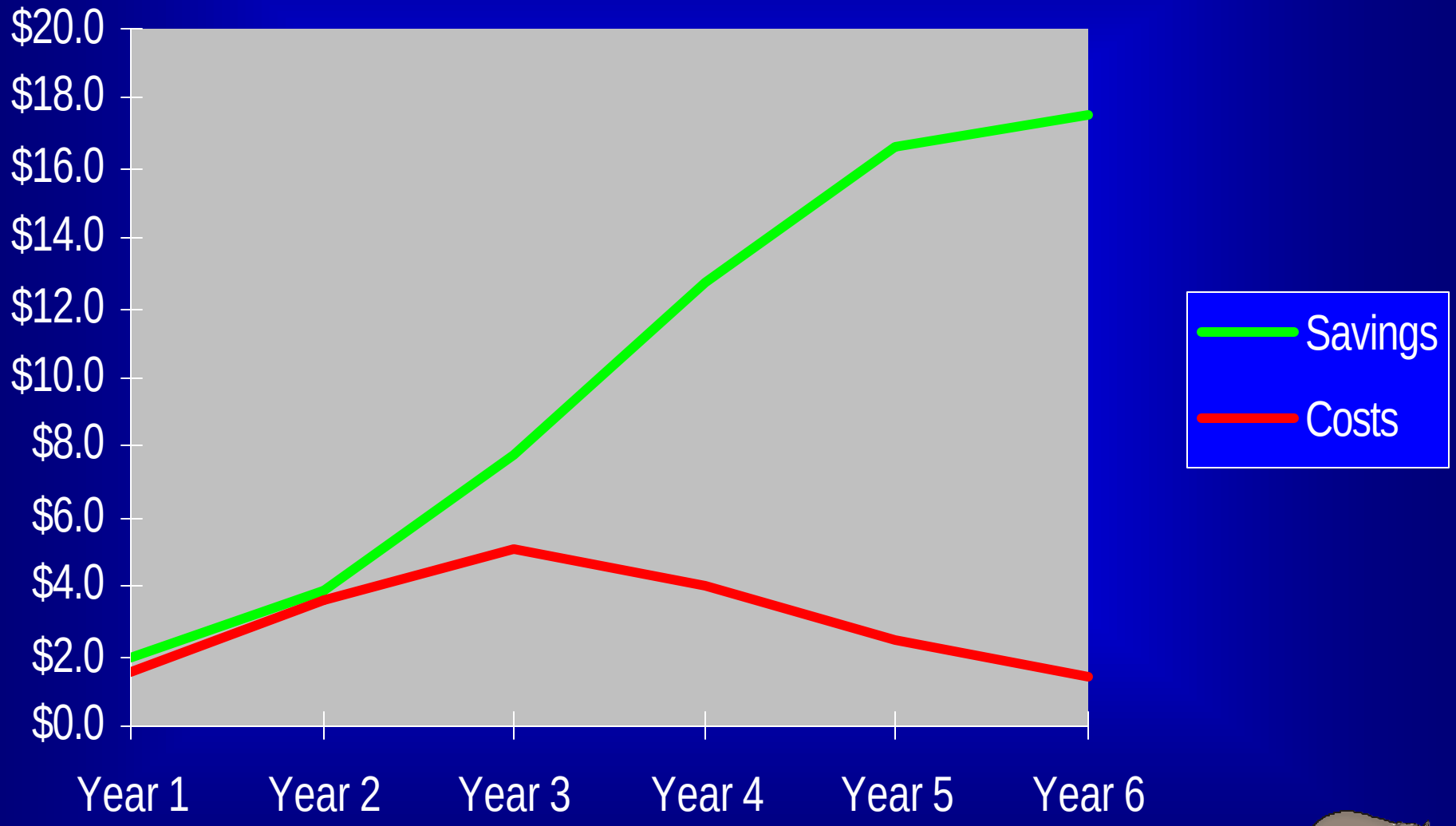
- Improve efficiency and effectiveness of health care system by standardizing the electronic exchange of administrative and financial data.
- Protect security and privacy of individually identifiable health information.





It's a package deal!

1993 WEDI Report - Net Savings Potential ($ Billions)



Cumulative Savings = $42 Billion

Who is Covered and When?

- **Covered Entities (statutory):**
  - All health **plans.**
  - All health care **clearinghouses.**
  - Health care **providers** who transmit health information electronically in connection with standard transactions.
- **When (statutory):**
  - Small health plans (annual receipts of $5 million or less): within 36 months of effective date.
  - Others: within 24 months of effective date.

HHS Required to Adopt Standards:

- **Electronic transmission of administrative and financial transactions** (including data elements and code sets)
  - List includes claims, remittance advice, status, referral certification, enrollment, premium payments, etc.
  - Others as adopted by HHS.
- **Unique identifiers** (including allowed uses)
  - Health care providers, health plans, employers, and individuals.
  - For use in the health care system.
- **Security and electronic signatures**
  - Safeguards to protect health information.
- **Privacy**
  - For individually identifiable health information.

Guiding Principles -A standard should:

- Improve efficiency and effectiveness or improvements in benefits from EDI transactions.
- Meet needs of the health data standard users.
- Consistent and uniform with other standards
- Low development and implementation costs.
- Supported by ANSI-accredited SDO.
- Timely development, testing, and updating.
- Technologically independent.
- Precise and unambiguous, but as simple as possible.
- Low data collection and paperwork burdens.
- Flexibility to adapt more easily to changes.

Statutory Consultations

- Consult with: 4 groups named in the statute --
  - National Uniform Billing Committee (NUBC),
  - National Uniform Claim Committee (NUCC),
  - Workgroup for Electronic Data Interchange (WEDI),
  - American Dental Association (ADA).
- "Appropriate Federal and State agencies and private organizations."
- "Rely on the recommendations of the National Committee on Vital and Health Statistics (NCVHS)."

Regulatory Consultations

- Designated Standards Maintenance Organizations (DSMOs) to review requests.
  - Accredited Standards Committee (ASC) X12,
  - ADA Dental Content Committee,
  - Health Level Seven (HL7),
  - National Council for Prescription Drug Programs (NCPDP), NUBC, and NUCC.
- Conclusions passed on to NCVHS which can then make recommendations to HHS.
  - To make process compliant with APA.

Individual Input

- Many opportunities for individual input:
  - participate in open SDO processes,
  - participate in WEDI Strategic National Implementation Process (SNIP),
  - attend and provide testimony at numerous public meetings (including those of NCVHS available via live webcast),
    - » see ncvhs.hhs.gov
  - comment during rulemaking comment periods,
  - communicate with HHS Secretary or staff.

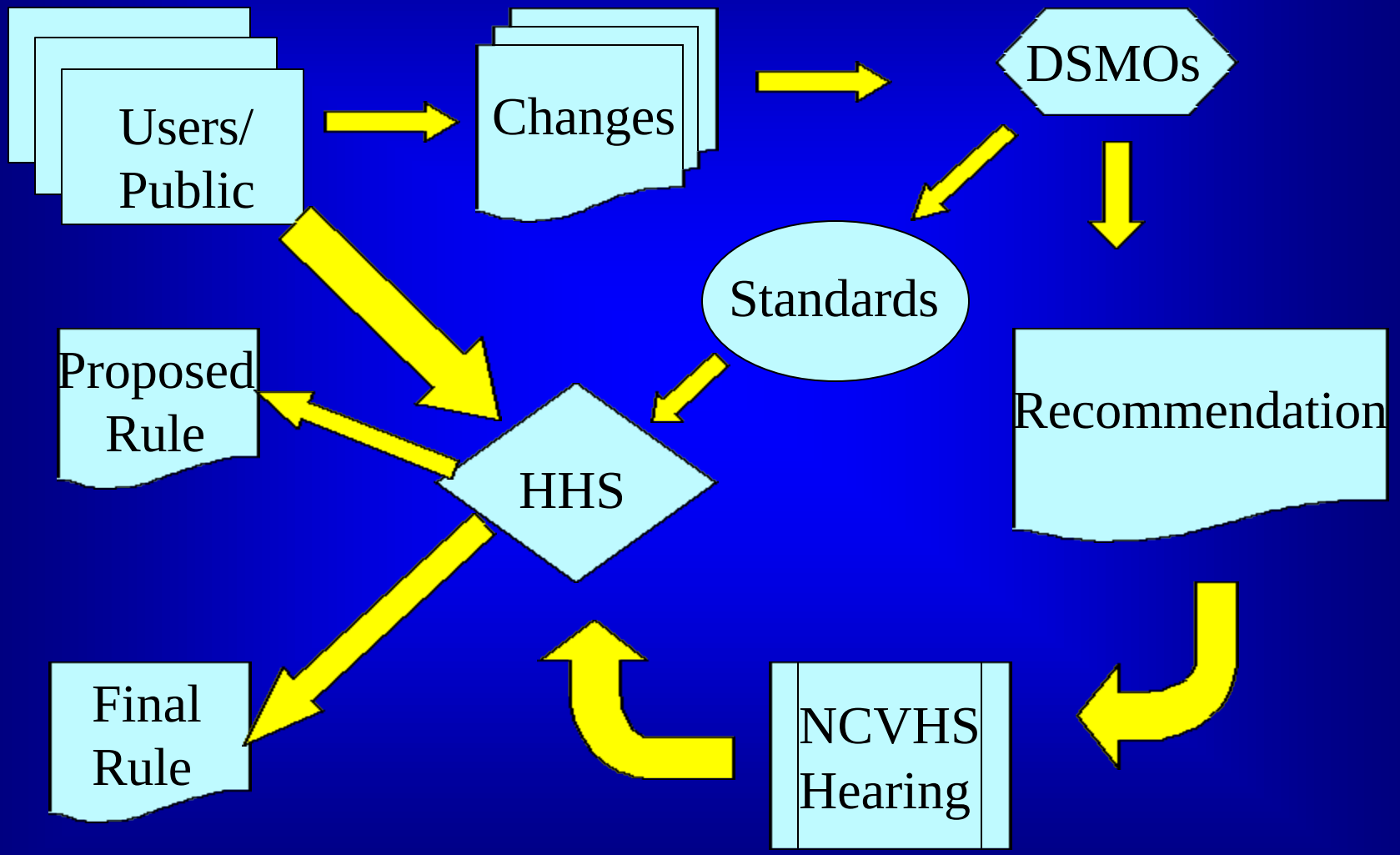
Expanded NCVHS Responsibilities

- NCVHS - HHS statutory public advisory body
  - in the area of health data and statistics.
- HIPAA expands responsibilities
  - on health information privacy,
  - on the adoption and implementation of standards,
  - on uniform data standards for patient medical record information and its electronic exchange.
- Reviewer of DSMO conclusions
  - for new and modifications to HIPAA standards.
- Public Health Data Standards Consortium.
- Annual report to Congress.

HIPAA Standards Philosophy

- To save money:
  - every payer must conduct standard transactions
  - no difference based on where transaction is sent.
- Standards must be
  - industry consensus based (whenever possible)
  - scalable, flexible, technology neutral.
- Implementation costs must be less than savings.
- Continuous process of rule refinement:
  - Annual update maximum to save on maintenance.
  - Faster emergency fixes to allow compliance.

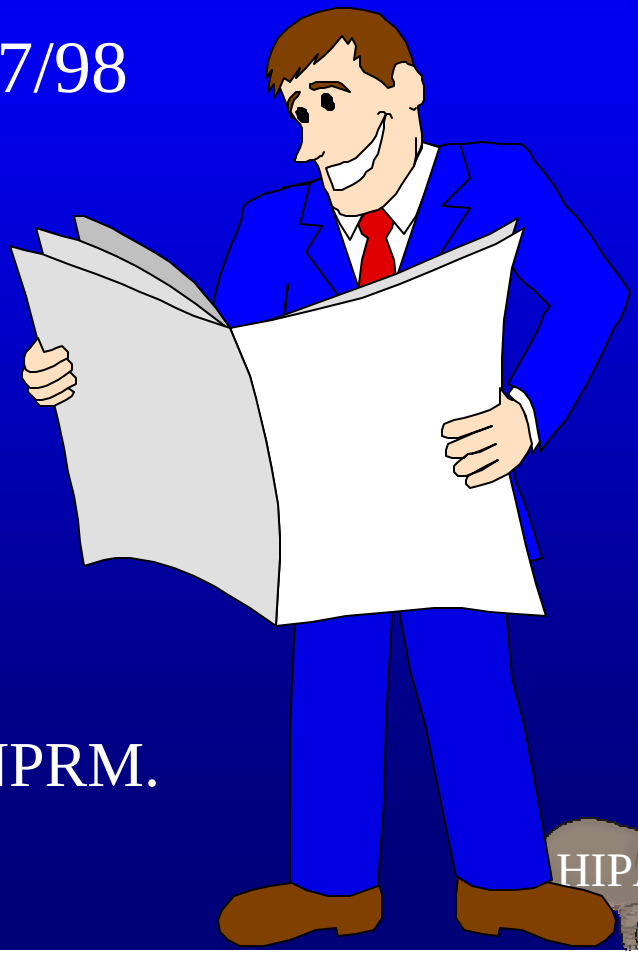
Standard Change Processes



HIPAA

Federal Register Publications

- Transactions NPRM - 5/7/98
  - » Final Rule - 8/17/00
  - » Compliance by 10/16/02
- National Provider ID NPRM - 5/7/98
- Employer ID NPRM - 6/16/98
- Security NPRM - 8/12/98
- Privacy NPRM - 11/3/99
  - » Final Rule - 12/28/00
  - » Compliance by 4/14/03
  - » Guidance issued 7/6/01.
  - » Modifications being prepared for NPRM.




The HIPAAs are Here!
Get On With It!

Transaction Standards

- Adopts ASC X12N standards for transactions (except NCPDP for retail pharmacy transactions).
- Adopts code sets in common use:
  - ICD-9 coding for diagnoses and inpatient services.
  - CPT-4 for professional services.
  - CDT-3 for dental services instead of ‘D’ codes.
  - [NDC for drugs instead of ‘J’ codes] being rescinded.
- Does away with ‘local’ codes
  - move to national HCPCS code system.
- Modifications to Standards (and Final Rule) now being evaluated for NPRM.

Identifiers

- Employers
  - Employer Identification Number [EIN]
  - Final Rule expected in 2001
- Providers
  - National Provider Identifier [NPI]
  - Final Rule expected in 2001
- Plans
  - National Plan Identifier [PlanID]
  - NPRM expected in 2001
- Individuals
  - On Hold

Security Requirements

- Covered Entities shall maintain reasonable and appropriate administrative, technical, and physical safeguards --
  - to ensure integrity and confidentiality
  - to protect against reasonably anticipated
    - » threats or hazards to security or integrity
    - » unauthorized uses or disclosures
  - taking into account
    - » technical capabilities
    - » costs, training, value of audit trails
    - » needs of small and rural providers

Key Security Philosophy

- Identify & assess risks/threats to:
  - Availability
  - Integrity
  - Confidentiality
- Take reasonable steps to reduce risk.

Maxwell Smart's Cone of Silence

HIPAA

Security Issues

- Covers data at rest as well as transmitted data.
- Involves policies/procedures & contracts with business associates.
  - For most security technology to work, behavioral safeguards must also be established and enforced.
    - » requires administration commitment and responsibility.
- Expect final rule by end of 2001.
- Electronic signatures:
  - Final rule will depend on industry progress on reaching consensus on a standard.

Electronic Medical Records

- Government CPR project: DoD, VA, IHS
- Private Sector Efforts: MRI, CPRI, IOM, etc.
- NCVHS Report (7/6/00) after 11 days of public hearings:
  - clinical and economic benefits related to electronic patient medical record information (PMRI),
  - major impediments to electronic exchange of PMRI,
  - recommendations related to the selection of PMRI standards,
  - acceleration of development of PMRI standards,
  - early adoption of PMRI standards, and
  - relationship of PMRI standards to other issues.
- Recommendations presented to HHS
  - currently under consideration.

Other Standards

- Claim Attachments
  - expect NPRM by end of 2001.
    - » (X12/HL7 joint IG).
    - » 1st six attachment types defined.
- Doctor's First Report of Injury.
  - X12 implementation guide completed.
  - expect NPRM in 2002.
- Enforcement rule may describe HHS process ...
  - Federal team working on NPRM.
  - expect NPRM in 2002.

Requirements for Privacy

- HIPAA requires:
  - Recommendations for legislation from the Secretary of Health and Human Services Sept. 11, 1997.
  - If legislation establishing privacy standards is not enacted by August 21, 1999, the Secretary of HHS shall promulgate final regulations containing such standards not later than February 21, 2000.
- Final Rule published 12/28/2000
  - Opened for comment for 30 days in March
  - Effective on 4/14/2001
  - Guidance issued 7/6/01
  - Compliance required 4/14/2003

Fair Information Practices

- "Records, Computers, and the Rights of Citizens" report by HEW Advisory Committee in 1973
  - led to Privacy Act of 1974 governing personal data held by US federal government.
- OECD Guidelines and COE Conventions in 1981
  - fed into bills that failed in US Congress.
- "Computer-based Patient Record" report by IOM in 1991 and WEDI reports in 1991and 1993
  - led to Administrative Simplification Law in 1994
    - » EDI and security and privacy standards.
    - » Passed as part of HIPAA in 1996.

Principles of Fair Info Practices

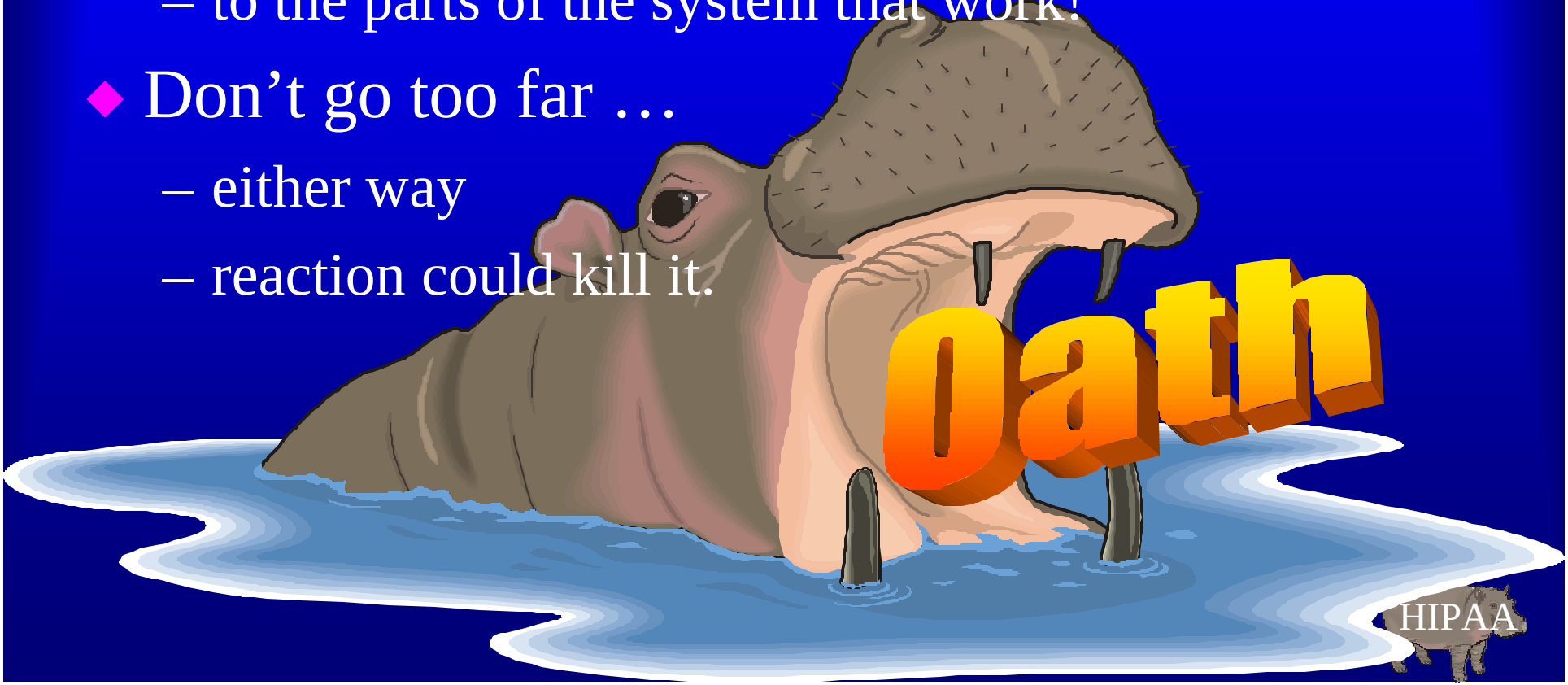
- Openness
  - existence and purpose of record-keeping systems must be publicly known.
- Individual Participation
  - right to see records and assure quality.
    - » accurate, complete, and timely
- Collections Limits
  - collected with knowledge and consent of subject.
- Use Limits
  - relevant to purpose for which data collected.

Principles of Fair Info Practices (2)

- Disclosure Limits
  - consent of subject or legal authority.
- Security
  - reasonable safeguards for confidentiality, integrity, and availability of information.
- Accountability
  - penalties and mitigation for violations.

Hippocratic Oath

- First, do no harm …
  - to the patient
  - to the provider
  - to the parts of the system that work!
- Don’t go too far …
  - either way
  - reaction could kill it.



Health Information Privacy

- Covers individually identifiable health information in any form held by a covered entity.
- Covers uses **and** disclosures of such information by a covered entity or business associate.
- Requires NO disclosures except to individual and HHS for enforcement.

Components of Privacy Rule

- Consumer control = rights for individual patient
- Boundaries on use and disclosure
- Balancing public responsibility with protections
- Ensuring security
- Accountability and penalties

Purposes of Guidance

- Clarify where rule was unclear.
- Explain rationale and expectations where rule has been misinterpreted.
- Debunk rumors.
- Identify errors that were made and that will be corrected through rule making.
- Identify policy areas that may/will be addressed in future rule making.

Updated Cost Estimates

- Net savings of $12.3 billion over 10 years.
  - Total savings of EDI standards (from transactions rule) of $29.9 billion over 10 years.
  - Partially offset by estimated cost of privacy implementation of $17.6 billion.
- Note:
  - federal estimates are only for those expenses *required* by the regulations.
  - Most efficient implementation requires process reengineering and potentially additional expenses.

Benefits of HIPAA Standards

- Lower cost of software development and maintenance.
- Assure purchasers that software will work with all payers and plans.
- Lower cost of administrative transactions by eliminating time and expense of handling paper.
- Pave way for cost-effective, uniform, fair, and confidential health information practices.
- Pave way for standards which can do the same for electronic medical records systems.
- Pave the way for higher quality health care.

Resources

- Administrative Simplification Web Site:
  - http://aspe.hhs.gov/admnsimp/
    - » posting of law, process, regulations, and comments.
  - instructions to join Listserv to receive e-mail notification of events related to HIPAA regulations.
  - submission of rule interpretation questions.
- Office for Civil Rights Web Site:
  - http://www.hhs.gov/ocr/hipaa/
  - for privacy related questions.
- Also see: - ncvhs.hhs.gov
  - www.hcfa.gov/hipaa/hipaahm.htm