

Health Policy, Legal and Ethical Issues

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Gandalf's Gang

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HIPAA and the Legislative Process

From the nation's founding Congress has been reluctant to provide specific interpretive guidance on any legislation passed, thereby upholding a longstanding American "tradition" of allowing a broad interpretive base for new laws. The tradition continues happily with the 1996 Health Insurance Portability and Accountability Act (HIPAA). Organizations and administrations affected by HIPAA were left without any clear guidance on how it should be implemented, and therein we begin our discussion of the many challenges facing managed health care under HIPAA's provisions.

Prior to the 1940's, Congress took little action towards regulating and managing the country's health care system. The first major change in policy came with the enactment of the Medicare/Medicaid bills. National regulation of state and local government programs was indirect and was usually conducted through the management of funds (i.e., grants-in-aid, block grants, etc). National policy required funds to be spent on specific programs, or required States to match a percent of the forecasted program cost before National funds were allocated. In most instances how legislation/programs were to be implemented, were left up to the States.

Unfortunately, with HIPAA, states and local governments are not the only interested parties or organizations that will be affected by the legislation. The nation's Health Care System (HCS) is much more complex and involves a large and varied group of stakeholders. Each interested and affected party (IAP) also has a different way of conducting business within the HCS. One of the biggest problems to overcome in the process of developing, enacting, and implementing legislation such as HIPAA, is communication and obtaining consensus among all IAPs.

The legislative process is complex enough without trying to formulate a single law that is supposed to solve all the problems and issues of such a complex system as our HCS. For HIPAA the legislative process began with a "relatively" few IAPs who lobbied Congress concerning three current health care issues: portability of individual health care coverage between employers, Administrative Simplification (AS) of the HCS, and the Confidentiality and Privacy (CP) of Personal Health Information (PHI). Some of the IAPs initially involved included the American Medical and Dental Associations, insurance companies, independent health care providers, hospitals, large corporations (payers) and other Business Associates (BA) involved in the healthcare network. How well Congress understood the issues and the implementation of our HCS, and how such broad legislation would impact the system is difficult to say, but after years of debate HIPAA was passed, and passed on to the Health and Human Services Department (HHS) for implementation. The HHS was directed to develop the rules and regulations of the legislation. The HHS, along with advice from other governmental offices, developed proposed rules and guidance such as: the

administrative and financial transaction standards and code sets, national provider identifier for healthcare providers, identifiers for health plans, identifiers for employers, and security standards to protect PHI. The proposed rules were reviewed, modified and approved within the government. Once approved the policies were published as a Notice of Proposed Rulemaking in the Federal Registry, where they remained for a period for public review and comment. This period of time allows IAPs, not privy to the internal mechanisms of the National Government, an opportunity to review and raise issues regarding the proposed rules before they become law. Throughout the entire legislative process there have been those opposed and those who supported the legislation. Opposition or support is usually a result of an IAP's desire for power/control and financial gain over competitors. Once the review period passed, the HHS set a time for the rules and regulations to be implemented by all IAPs.

Since 1996 dates for the implementation of various regulations have come and gone, and IAPs are still struggling. It would seem (from the outside) that the national government and IAPs involved in the legislative process did not fully comprehend the intricacies of our HCS, the number of IAPs involved, and the effect the legislation would have on the corporate and individual players. Perhaps IAPs were too concerned with maintaining their power, control and lead within the healthcare market. Whatever the reason for poor management, communication, and ineffective legislative development, IAPs are now scurrying to meet deadlines set by HHS. Two parts of HIPAA's rules and regulations that IAPs are having difficulty in understanding and implementing are Administrative Simplification (AS) and Confidentiality and Privacy (CP).

Goals of HIPAA

Through the use of electronic standardized codes and forms, the goals of HIPAA's AS rules and regulations were intended to minimize the overall administrative expenses and efforts associated with enrollment eligibility, claims processing, account posting, claim follow-up, referral and prior authorization process. It has been estimated that implementation of this process would save IAPs \$9-42 billion dollars in the first six years. Of course others estimate the cost of implementation to be more than 1.5 times the cost of Y2K. The goals of HIPAA's CP rules and regulations were intended to protect PHI due to increased technological advances and ease with which medical health data is transmitted, stored and used by multiple IAPs. The forecasted benefits of HIPAA were to increase overall efficiency and effectiveness of business management practices through improved communication and coordination and safeguard PHI. Benefits were to be experienced by all IAPs such as providers, administrators, and patients. Unfortunately there have been some unforeseen complications in the implementation of the new AS and CP policies.

Impact of Administrative Simplification

The goal of AS was to reduce administrative costs by eliminating, reducing and/or consolidating healthcare information systems in use by IAPs. The greatest impact on providers will be cost, especially for mainstream established firms. New companies have an advantage, because they can implement the new rules into their management plans. Older companies are faced with having to re-engineer their business processes. The impact is insidious. It will not only affect how an individual business operates, but will affect an entire network of businesses, because for them to be competitive and compliant; in order for them to function and communicate, they will all have to adopt similar, technological equipment and processes. To ensure businesses are compliant and personnel understand the rules and regulations, additional staff will have to be hired, who are trained on the current laws, can train the healthcare staff, and manage and evaluate the implementation of the new requirements. It will take time, but it is surmised that the new AS requirements will reduce storage space, improve healthcare staff access to information (i.e., inquiry and response), increase operational efficiency, improve legibility, and potentially reduce errors.

Administrators will also feel the impact of HIPAA. Maybe more so than any other section of the healthcare industry, administrators will be the first who will need training on the new requirements. Before any of the benefits are realized, administrators will have to understand and map the flow of PHI within their organization and perhaps that of their BAs. They will have to conduct information gap analysis, adjust policy procedures, and eventually assess compliance. They will also have to become knowledgeable on how current laws and the new HIPAA rules interact. In fact, administrators may be the ones assigned to implement and manage the new legislation and train the rest of the staff. In a competitive market, and in instances where business are forced to implement new requirements, the administrators will also be looking for ways to reallocate resources. Funding for programs may have to be cut or reduced in order to fund implementation of HIPAA. A reduction in staffing may result, or the staff may have to increase their workload. In the end HIPAA proclaims that administrators should see an increase in the ease of enrollment, eligibility verification, referral authorization and payment tracking. The increase in administrative responsibility could be seen as a benefit in terms of jobs security and the creation of additional jobs in the market place.

As a result of re-engineering, companies just don't eat the accrued costs, they pass the costs on to the consumers. The implementation of AS rules may increase enrollment and available appointments, and improve the portability of PHI from insurer to insurer, but at what cost to the patient? If healthcare costs rise due to the cost of implementing HIPAA, this may have a reverse effect and instead restrict patient access to healthcare.

A good example of an attempt at AS, on a much smaller scale, is the creation of the CHCS system in military medicine. You would think that an organization as structured as the military would find it easier to implement an AS system, but each department of the military has created its own implementation policy and procedures. Implementation of CHCS has faces similar problems, as will HIPAA, namely standardization, personnel turn-over and training, space, equipment, and funding. By utilizing new technology, the goal of HIPAA's AS to improve communication is commendable, however too much access can adversely affect the confidentiality and privacy of PHI.

Impact of Confidentiality and Privacy

CP rules were made a part of HIPAA as a result of Congress' recognition that additional controls needed to be added to safeguard PHI. The impact of increased protection of PHI on providers may include limited access to information, litigation concerns, additional training needs, and changes in organizational climate/culture. Providers may find that the amount of time they normally spend with a patient has been limited, because they have to spend a portion of their time informing the patient of their rights and responsibilities with regard to consent and disclosure of PHI. Staff members may experience a change in the organization's climate. Patient and provider relations may be affected due to concerns regarding oral communication and privacy. Providers may find it difficult to balance CP rules and regulations and the need to provide a relaxed atmosphere for both patients and staff. A greater impact on providers may be their reluctance to share PHI for fear of litigation. One of the primary partners of healthcare providers is healthcare researchers. Much of their PHI comes from providers. If providers become reticent about divulging PHI, this may restrict the amount, type, and speed with which research is conducted. This, in turn, may decrease the amount of new scientific information available to providers.

Along with the provider, administrators will also face the burden of ensuring staff, patients and BAs understand PHI privacy and confidentiality requirements. Administrators may be forced to identify/assign or hire additional staff as Privacy Officers (PO). The PO's role would be to implement CP policy and evaluate organization and its BA's compliance. Whereas AS is supposed to reduce the administrative burden and improve network communications, CP regulations may have the opposite effect.

Patients will also be affected by CP rules. The benefit to patients will be in the form of increased control over their PHI, how it is shared, distributed and used. Control of PHI may reduce the likelihood that patients may be determined to be ineligible for medical coverage, by insurance companies, due to pre-existing conditions. The drawback is that patients will have to become better informed about their rights and responsibilities. As yet it's not certain who will be responsible for training patients. Other IAPs may feel that patients may not fully

comprehend or misinterpret CP requirements, and like providers, their increased control, along with misperceptions, may lead to a decrease in PHI access for researchers.

An example of the impact of CP on the use of new AS technology, is the development of portable electronic medical records and smart ID cards. The development and issuance of military ID cards that have computer chips able to store PHI has been available for a few years. However, personnel data has not been stored on the card. The roadblock may stem from the inability of developers and managers to answer CP issues.

Changes Imposed on Managing Health Systems

The potential challenges imposed on managing health systems in implementing AS and CP requirements will be to the systems cost, quality and access. Initially, businesses will experience increases in cost related to more training, equipment, and personnel needs. Over time, and with technological advances, program costs should decrease and businesses should see an overall improvement in operational efficiency, within their organization and between their BAs. Health systems may experience growing pains as the rules are adopted; however, standardization of business communication should improve efficiency (output). This doesn't mean that patients will experience an increase in quality (outcome). In fact, if health systems are not effectively managed, and the effects of AS not analyzed, the results may be a decrease in patient access. Health systems will also be challenged by CP rules. Researchers may face the greatest challenge. If access to PHI is suddenly curtailed, researchers may have to devise new and costly techniques. The cost of research may increase if the quality of results is to be maintained.

Conclusion

HIPAA may be trying to bite off more than the IAPs can chew and digest. The goals of HIPAA are admirable, however its creation and implementation has and continues to have many barriers. Healthcare needs standardization, but it may come with a high price tag. It will require significant efforts in coordination and communication, from all levels of government and the healthcare community. Change within a complex system such as healthcare is incremental, and it may be an eternity before positive results are realized. By then, there will be new issues that require system modification and newly amended laws that allow us to continue our longstanding tradition of broad-based interpretation.