

Why HIPAA Hasn't Hit

In August 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law.

By all rights, it seemed like a good idea: mandate standards for the electronic transfer of administrative and financial healthcare-related information and save billions of dollars in costs each year. It didn't impose rules and regulations unnecessarily, because the standards apply primarily to payers and clearinghouses, as well as those providers who choose to transmit information electronically. And the implementation timeframes were reasonable — 18 months to adopt the standards, then another 24 months to implement them.

Road Paved With Good Intentions

The driving factor behind the legislation in the first place was that an uncommonly high percentage of every dollar spent on healthcare-related services in the U.S. goes toward administrative overhead. This includes processes for:

1. Enrolling individuals in health plans.
2. Paying health insurance premiums.
3. Checking insurance eligibility.
4. Authorizing a patient's referral to a specialist.
5. Filing claims for payment of healthcare services.
6. Requesting or responding to additional information in support of a claim.
7. Coordinating the payment of claims involving two or more insurers.
8. Notifying providers about the payment of claims.

Estimates on the savings that could be realized by moving these tasks from manual, paper-based transactions to electronic transmissions range from \$9 billion - \$42 billion in the first six years.

The Complicated Business of Administrative Simplification

One part of the 1996 law, Administrative Simplification, targeted the high cost of paper-based transactions. It required the secretary of the Dept. of Health and Human Services (H & HS) to adopt "national uniform standards" for their electronic transmission. But between the passing of the law and the deadline for adopting standards, something went slightly awry.

The February 1998 adoption deadline came and went. And, while H & HS has made good headway, it's evident that both the process and the healthcare industry are more complicated than first glance revealed.

So what exactly went wrong? H & HS officials give two main reasons for the delay:

1. Complexity of the issues involved; and
2. A cumbersome review process.

What they didn't mention is that the complexity increases because there are a number of different types of organizations affected, including:

1. Government and private health plans, insurers and administrators.
2. Hospitals, physicians and care providers.
3. Employers.
4. Clearinghouses.
5. Value added networks (VANs).
6. Translator vendors.
7. Hospital and practice management system vendors.
8. Billing agents.
9. Other service organizations.

And for each type of organization, there are a number of very specific implementation requirements, steps, and issues. But perhaps the most complicated part of the entire undertaking is the review process.

Despite the goal of simplification, the process is far from simple. The short description of the process includes the following steps:

1. Identify existing standards that could be adopted.
2. Analyze existing standards, identify gaps and conflicts.
3. Develop recommendations for standards to be adopted.
4. Publish proposed rules outlining the standards in the Federal Register for 60-day public comment period.
5. Analyze comments and prepare and publish final rules.
6. Distribute standards and prepare and distribute implementation guides.

But what this description doesn't show is how complicated steps 3, 4 and 5 really are. Because the final rules will have the force of Federal law, the process to develop them is designed to achieve consensus within H & HS and across other Federal departments.

Here's how it works:

First, H & HS Implementation Teams draft Notices of Proposed Rule Making (NPRMs) for the following:

1. Administrative and financial transaction standards and code sets;
2. National provider identifiers;
3. Identifier for health plans;
4. Identifier for employers; and
5. Security standards.

Then, each NPRM is reviewed and approved within the Federal government to answer and resolve governmental questions and concerns. This within-government review is a three-stage process by which the NPRMs are approved by:

1. *The H & HS Data Council's Committee on Health Data Standards*, which is responsible for overseeing the entire AS implementation process for the Secretary of H & HS.
2. *Advisors to the Secretary within H & HS*, who are heads of divisions that may be affected by the proposed standards or are responsible for particular issues (e.g., the impact of the standards on the Federal budget).

3. *The Office of Management and Budget*, which reviews the NPRMs from a government-wide perspective and circulates the NPRMs for review by Federal departments other than H & HS.

Once this internal review process is complete, the NPRMs can finally be published in the *Federal Register* for public comment. Public comment on the NPRM is used to fashion the final rule.

Only Time Will Tell

In the beginning, officials in the Health Care Finance Administration (HCFA) had anticipated publishing the proposed rules in early spring 1998. They did reach that goal -- almost. However, so far, the rest of their initial scenario -- which called for final regulations to be published in late 1998, and therefore healthcare organizations' compliance in late 2000 -- has not held true.

While the delays mean the continued high cost of healthcare, there are some positives. First, it means healthcare has a bit more time to corral the necessary resources to comply to the final rules once they are published. Second, the extra time will keep new regulations from hitting at the same time as any potential Year 2000 issues.

But we can't let these delays lull us into a sense of false security. H & HS is very clear on one thing: The standards become effective 24 months after adoption for most organizations and delays in adoption of the standards will not shorten these periods for implementation.

Whether or not healthcare takes advantage of the breathing room it has been granted could mean the difference between a difficult transition and an impossible one. Even though the clock is ticking, it would be wise for healthcare to realize that the extra time is time on our side.