HIPAA: Lack of Standardization

★ Overview

In 1996 Congress acknowledged the need to simplify the administrative processes involved in health care operations by passing the Health Insurance Portability and Accountability Act (HIPAA). Congress' clear objective in enacting the administrative simplification provisions was the creation of standard health care transactions to achieve greater operational efficiencies in the administrative and financial processes of health care, resulting in a reduction in overall administrative costs. Prior to the law's enactment, individual health plans had the ability to require providers to capture unique data in order to receive payment for services, resulting in reduced efficiencies and increased costs associated with manual processes. The intent of HIPAA was to streamline the nearly 400 data formats to a single format to process claims, thereby decreasing the administrative costs of health care providers to bill and receive payment for services, as well as reduce health plan resources used to adjudicate claims.

★ Background

The administrative simplification provisions were originally scheduled for implementation October 16, 2002, but due to the complex nature of this regulation and lack of overall industry readiness, the implementation deadline was extended for one year to October 16, 2003. By that date, overall HIPAA readiness was beginning to progress, though it was evident compliance on a broad scale with all nine transactions identified by the administrative simplification provisions would not be achieved. The Centers for Medicare & Medicaid Services (CMS), which is the oversight body for the laws, as well as the United States' largest health plan and therefore a HIPAA covered entity, allowed the industry to implement contingency plans post 2003 to maintain the integrity of the health care delivery system while efforts continued to reach compliance. While compliance with the regulations continues to grow, it remains clear industry-wide compliance with all the standardized transactions will continue to struggle due to the intricate relations among organizations to conduct transactions.

The administrative simplification regulations are unlike any other law due to the fact that each health care provider is dependent upon its health information software vendor and clearinghouse vendor to create compliant transactions and then deliver them to health plans. Implementing this regulation has been further complicated by allowing individual health plans to continue to require unique data in order to process health care claims. The unique health plan data requirements, defined in health plan companion guides, are a result of divergent interpretations of the law and a lack clarification. The birth of companion guides has all but *ceased any potential of reduced administrative burden and costs on the part of providers.*

In addition to the continued complexity of the HIPAA standard transaction code sets, each state's Medicaid claims processing system is paling in comparison with other payers and covered entities progress in reaching compliance with even *one of the nine transactions*. With the current economic

crisis every state is experiencing, the increased number of individuals enrolled in both the Medicaid and State Children's Health Insurance Programs each year, the Medicaid fiscal agents lack of progress in reaching compliance only exacerbates inefficiencies within the program, and therefore creates further administrative burden and expense for both the Medicaid programs and providers.

★ **AAHAM Position**

• **Congress should urge HHS to establish a mechanism for resolving differences of interpretation of standards and implementation specifications in order to achieve true uniformity and thus administrative simplification.** Currently, there are hundreds of companion documents, each with a different set of interpretations for conducting the standards. The divergent interpretations and creation of companion documents threatens to defeat the goal of Administrative Simplification.