

Keeping Pace:

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by | **Bill Wekluk**

The Role of Technology in Regulatory Compliance



A plan sponsor's computer system and technology vendor should be flexible resources in efforts to comply with recent and not-so-recent government regulations stemming from HIPAA, HITECH and health care reform.

In the last three years, health and welfare plans across the country have witnessed an unprecedented surge in new regulatory requirements. Government initiatives including the American Recovery and Reinvestment Act (ARRA), Health Insurance Portability and Accountability Act (HIPAA), Medicare and health care reform have mandated a myriad of changes. Though each regulatory change has impacted plans in different ways, flexible technology has been the main catalyst for achieving overall compliance.

This article reviews the challenges facing health plan administrators, trustees and consultants and discusses the role technology has played, and will play, in meeting evolving compliance standards. It looks at where the industry may be heading by examining what we've learned from prior legislative regulations and what we're learning from current initiatives.

What We Have Learned

It seems like much of the last three years has been spent researching new legislative requirements, determining our respective responsibilities under the legislation and implementing the necessary solutions for compliance. In doing so, we've learned quite a bit.

Lesson 1: Nothing Is Static

With almost all of the legislative requirements health plans have faced in the last few years, the rules for compliance—or at least some of the particulars—seemed to evolve over the course of several months. A case in point: the Medicare Secondary Payer (MSP) mandatory reporting requirement introduced over three years ago.

The Centers for Medicare and Medicaid Services (CMS) now requires all group health plans (GHPs) to report member and beneficiary data on a quarterly basis. MSP reporting, also known as Section 111 reporting, helps identify those persons who may be primary with Medicare. Because CMS requires data transmissions in a specific electronic format with mandated data elements, many GHPs rely on their technology vendors to create and transmit quarterly files. While GHPs have been submitting files to CMS for over a year now, CMS continues to hold Town Hall Teleconferences to assist responsible reporting entities (RREs) with ever-changing regulations. These teleconferences are already scheduled well into the summer of 2011.

Shortly after the MSP reporting requirements for GHPs were finalized, CMS provided further clarification on the reporting requirements for health reimbursement arrangement (HRA) plans. Since the inception of the MSP reporting requirement, CMS has issued well over 20 “alerts” to provide subsequent or clarified reporting requirements.

The good news is that someone is listening. In almost all of the recent legislative initiatives impacting the industry, the government entity responsible for the requirement (CMS, Department of Labor, etc.) has established some means of providing feedback. In most cases, the initial legislation is released in an all-encompassing manner—basically a cookie-cutter approach in an industry filled with unique organizations. The RRE then awaits feedback, provides answers and makes required adjustments.

Fortunately, the groups affected are not shy. They provide feedback and request clarification on their specific situations. Government websites have been flooded with questions from industry professionals, such as, “This law seems to apply to fully insured plans, but what does it mean for self-insured plans?” or “How does this particular piece of legislation affect Taft-Hartley plans?”

This type of feedback, and the government entities' willingness to listen, has led to continually evolving legislation. It also led to Lesson 2.

Lesson 2: Deadlines Might Not Be Extended

Extended deadlines for compliance have been common for many of the new legislative requirements we've seen over the last few years. MSP reporting, the Health Information Technology for Economic and Clinical Health (HITECH) Act and International Classification of Disease, Tenth Revision (ICD-10) code compliance have all had extensions to some of their original due dates.

However, it cannot be assumed that all deadlines will move. One major example of this was the COBRA Continuation Coverage Assistance, or COBRA subsidy program. Under this program, assistance-eligible individuals paid 35% of their COBRA premiums. The federal government subsidized the remaining 65% in the form of a tax credit back to the health plan.

Almost immediately after the passage of ARRA, the industry was thrust into a frenzy to comply with the new program. As details of this plan unfolded, information technology (IT) professionals and plan administrators scrambled to

meet the notification and administration requirements set forth in an extremely aggressive time line. For most health plans, extensive system modifications were required to help identify those terminating members who were eligible for the subsidy, as well as to modify COBRA notification and election notices to incorporate the new subsidy language. Additional modifications were needed to allow for the collection and tracking of the 35%/65% split, as well as for the proper subsidy reimbursement procedures to the federal government.

Ironically, the mandated start date for the COBRA ARRA subsidy program was never extended, but the end date was. Congress granted two separate extensions that allowed additional terminated members to take advantage of the program.

Lesson 3: Legislative Initiatives Are Not Temporary

With the exception of the COBRA ARRA subsidy program, which ends with members who qualified on or before May 31, 2010, almost all legislative compliance initiatives that were launched over the last few years are still in place today.

One of the broadest pieces of legislation still affecting the industry is HITECH, included as part of ARRA, which was signed into law by President Obama on February 17, 2009. HITECH is extensive in scope and addresses many issues, ranging from the responsibilities of business associates under HIPAA to a plan's breach notification requirements for the unauthorized disclosure or use of protected health information (PHI) deemed to be unsecure.

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From the technology perspective, HITECH is a critical piece of legislation because it provides incentives for the development and utilization of electronic health records. It also established penalties for those covered entities that do not properly secure PHI. HITECH set forth very specific "guidance" pertaining to the use of technology in securing PHI. In a nutshell, it mandates that encryption methodology be used in every instance where PHI may exist—specifically, data at rest, data in motion, data in use and data disposed.

It is impossible to discuss the current state of legislative compliance requirements without discussing health care reform. The Patient Protection and Affordable Care Act continues to have a profound effect on health and welfare plans across the country. Whether removing annual/lifetime plan limits or extending the coverage of dependents to the age of 26, industry professionals have been tasked with a monumental undertaking to remain compliant.

It is too early in the process to look back and identify all we have learned because health care reform is far from over. There will be more change, and we will need to be in a position to conform

both technologically and administratively.

Lesson 4: Flexibility Is Key

So now we know that legislative initiatives change frequently, their deadlines can be instantaneous and rigid, and their compliance requirements usually last for a very long time. Everyone affected by these types of legislative requirements should ask themselves one important question: Can my computer system and my technology vendor keep up?

The answer should be fairly clear-cut. In most cases, a plan sponsor's computer system and technology vendor will either be flexible resources the sponsor can count on, or they will be an Achilles heel, making the road toward compliance a long, expensive and arduous one. Flexible computer solutions and industry expertise are an absolute must for the future.

What Does the Future Hold?

The direction of health care reform probably will drive many regulatory compliance requirements in the future. At this point, there are a few specific upcoming compliance deadlines to anticipate:

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EDI 5010 and ICD-10

With compliance dates of January 1, 2012 and October 1, 2013, respectively, Electronic Data Interchange (EDI) 5010 and ICD-10 are sure to be topics of much discussion for the next few years. EDI is a set of technology principles that standardize the transmission of data from one computer system to another. IT professionals throughout the health care industry have already begun the arduous task of converting computer systems to migrate from the original HIPAA-mandated EDI 4010 transaction sets to the new EDI 5010, along with the transition from the traditional ICD-9 diagnosis codes to the new ICD-10 code standard. Plan sponsors that haven't already done so need to check with systems providers about the status of their efforts.

Unfortunately, if the time it took the industry to implement the EDI 4010 transaction set is any indication of the time required for 5010, January 1, 2012 doesn't look promising. A sweeping adoption of the 5010 standards across the industry is not likely anytime soon. Some of the largest insurance carriers and claim payers are still using proprietary data layouts for their electronic claims-processing systems. Some have yet to implement the original EDI transaction sets. These groups are faced with a leap forward of two full generations in technology.

It is safe to assume at this time that only those groups that are highly proficient with the EDI 4010 process, and that have already started the testing phase of the EDI 5010 process, will be ready for the January compliance date. On a more positive note, support for the new ICD-10 codes is a component of the new EDI 5010 requirements. Much of the ICD-10 work will need to be done prior to January 1, 2012 in order to reach EDI 5010 compliance, making the October 1, 2013 date for ICD-10 much more attainable.

Data. Data. Data. It's All About Data

We've all heard the expression, "Information is power." This cliché has never been more relevant than now, especially when applied to health care data.

The future is likely to involve large-scale efforts of data mining. Merriam-Webster defines *data mining* as "the practice of searching through large amounts of computerized data to find useful patterns or trends."

Many private firms and health plans have been data mining for years. It is used extensively across the health care industry to help forecast future costs, to help control utilization and to assist with health care cost containment. Many entities use data mining as a tool to identify subrogation-eligible claims as well as claims that may be fraudulent or improperly billed. Data-mining efforts are usually the precursor to larger preventive care and healthy living initiatives.

The benefits of these large-scale data-mining efforts have been proven at the individual health plan level, and now state governments are implementing legislative initiatives to collect data for statewide analysis. For example, the Office of Health and Human Services in Massachusetts has created an All-Payer Claims Database (APCD). The APCD requires all fully insured and self-insured plans to submit medical, eligibility, pharmacy, dental, Medicare and provider claims data to the commonwealth on a regular basis, in a file format mandated by the Massachusetts Division of Health Care Finance and Policy.

According to the www.mass.gov website, the objective of the APCD is "to provide timely, valid, and reliable health care claims data for the purposes of informing the development of health care policies in the Commonwealth and inform the development of performance measures to evaluate payment methodologies and support integrated health care delivery models." The state hopes that the APCD will encourage "administrative simplification" and "promote transparency initiatives." When complete, the database should enable "a broad understanding of cost and utilization across institutions and populations."¹

These types of large-scale claims databases are increasing in popularity. The map shown in the figure identifies those states where some form of an APCD is underway.

So what does all of this mean? Should we assume that since more and more organizations are data mining claims information at the plan and state levels that we should expect a national claims database?

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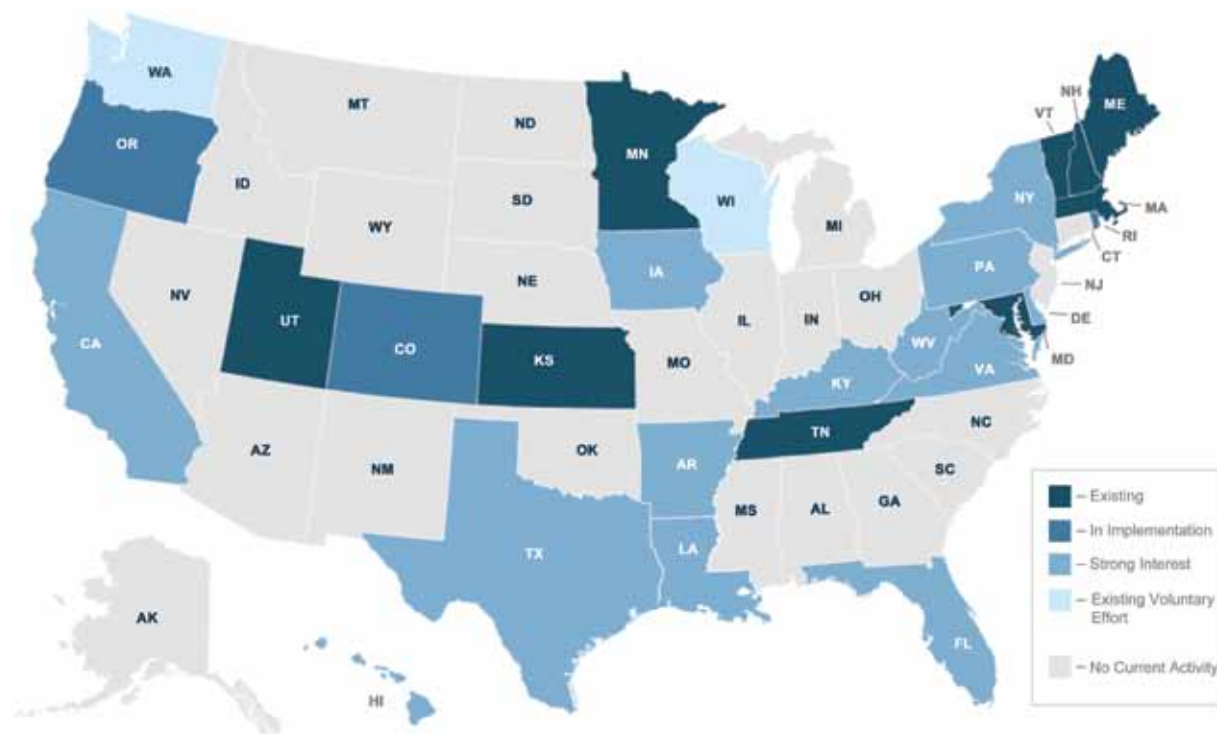
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FIGURE >>

States Where Some Form of APCD Is Underway



Map reprinted with permission from the APCD Council (www.apcdouncil.org).

From the technology perspective, such a project would be massive in scope. But it is becoming more and more feasible as electronic claims processing becomes increasingly pervasive and standardized. While many EDI programmers and analysts will joke that there is nothing standard about the HIPAA EDI standards, it is precisely the exercise of conforming the country's health care payers into a uniform set of electronic data files that could make a national database of claims information plausible.

HIPAA

Logistically and organizationally, it is likely that HIPAA will be the plat-

form by which most future regulatory requirements are established and enforced. Believe it or not, HIPAA turns 15 years old this year, and it continues to evolve and reshape the industry on a regular basis.

As discussed earlier, the HITECH Act was significant in its scope and requirements. HITECH tightened up some loose ends and closed a few loopholes in the HIPAA Privacy and Security Rules, strengthened the overall requirements under HIPAA, and clarified penalties for noncompliance.

But while the published requirements set forth in HITECH are significant, the underlying inferences that can be drawn from HITECH may have

even more of an impact. Many people believe that HITECH, as a component of ARRA, also established the funding and framework to begin the enforcement of HIPAA. Up until this point, HIPAA has been pretty much self-policing for most health plans. Times are changing.

One of the many lessons we can take from HITECH is that HIPAA is here to stay, and it is reasonable to expect it will continue to evolve. HIPAA may need to be amended to address future technologies and the benefits and potential threats that accompany them. Even more likely will be the need for

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takeaways >>

- The rules for complying with most legislative requirements seem to evolve over several months.
- Don't assume compliance deadlines will be extended or that legislative compliance initiatives will go away.
- HITECH provides incentives to develop and use electronic health records, as well as punishing entities that don't secure personal health information.
- Stay tuned for the future regulatory compliance requirements that will be created by health care reform.
- Data mining will only increase. A national claims database may not be farfetched.

HIPAA modifications to address future health care reform byproducts, such as the new state-regulated health insurance exchanges. In any case, plan sponsors should prepare for more change.

Conclusion: Keep Flexible to Keep Pace

As health care reform continues to mature and we begin to quantify the results of current initiatives, we will likely see new legislative and compliance requirements enacted to correct what hasn't worked and to expand on what has. Paradoxically, the technology we so heavily rely on to comply with industry standards will also be the catalyst for additional legislation. It is imperative that plan sponsors prepare for this now. Flexible systems and solutions that can adapt quickly to meet changing requirements, along with industry-specific expertise and experience, will be critical to keeping pace. 📍

Endnote

1. More information is available at www.mass.gov/dhcfp/apcd.