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Final Report
of the

Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-party Payors of Health Care Benefits

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Executive Summary

The Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-party Payors of Health Care Benefits was established by Resolve 1997, chapter 63. The Task Force was charged with both exploring the feasibility of a single claims processing system for third-party payors of health care benefits and the feasibility of streamlining the current claims processing systems used by payors.

The Task Force included legislators and members representing the interests of the Bureau of Insurance, the Department of Human Services, physicians, pharmacists, community mental health providers, home health care providers, hospitals, nonprofit hospital and medical service organizations, commercial insurers and employers. The duties of the Task Force were to:

- gather and examine information from other jurisdictions that have implemented a single claims processing system or have implemented a streamlined claims processing system;

- identify barriers and problems that need to be addressed to implement a single claims processing system or to streamline the current claims processing system;

- determine resources necessary to implement a single claims processing system or a streamlined system and develop a model for a single claims processing system;

- determine the impact on health care providers and health insurance carriers in a single claims processing system or a streamlined system; and

- identify the necessary steps for protecting the confidentiality of medical records and proprietary information in a single claims processing system or a streamlined system.

In its work, the Task Force addressed the structure of the current system and the problems faced by health care providers and payors. It also addressed the ongoing efforts to streamline and simplify health care transactions, including claims processing, at the federal level, in other states and in Maine.

The Task Force makes the following findings and recommendations.

The Task Force declines to develop a model for a single claims processing system for the State.

The Task Force does not support a state-mandated single claims processing system or state laws requiring the electronic submission or acceptance of health insurance claims.

The Task Force recommends that efforts at improving the current claims processing system focus on front-end processing to assist health care providers by building on the existing and emerging infrastructure, expertise and technology throughout the State.

The Task Force finds that market forces and cost savings will create the incentives to participate in private sector health information networks and claims clearinghouses as a means for providers and payors to reduce the administrative burdens of claims processing.

The Task Force recommends that providers and payors should be encouraged to use technology to access private health information networks or claims clearinghouses to simplify the submission of claims.

The Task Force finds that government efforts to encourage continuing development of technology and standardization of claims processing and health information are being undertaken currently at the federal level through the passage and implementation of the Health Insurance Portability and Accountability Act's administrative simplification provisions. The role of state government in improving the claims processing system should be reevaluated after the federal laws and regulations are adopted and implemented.

The Task Force finds that the issues related to the confidentiality of health information in an environment of electronic claims processing, single claims processing system or private health information network are being addressed adequately.

The Task Force recommends that legislation be introduced in the First Regular Session of the 119th Legislature to reconvene a study of the current claims processing system to monitor the development of standards for electronic claims processing and the efforts in the private sector at improving the system.

Introduction

The Task Force to Study the Feasibility of a Single Claims Processing System for Third-Party Payors of Health Care Benefits was established by Resolve 1997, chapter 63. The legislation creating the task force was introduced by Rep. Elaine Fuller and brought before the Joint Standing Committee on Banking and Insurance. The Task Force was required to look at both the feasibility of a single claims processing system for third-party payors of health care benefits and the feasibility of streamlining the current claims processing system used by third-party payors.

The Task Force was convened by Rep. Elizabeth Mitchell, chair of the Legislative Council, and met three times, on October 28, November 12 and November 25, 1997. Members of the task force included legislators and representatives of the Bureau of Insurance and Department of Human Services; physicians, pharmacists, mental health, home health and other health care providers; hospitals; nonprofit and commercial insurers; and employers.

The Task Force had the following charges:

- gather and examine information from other jurisdictions that have implemented a single claims processing system or have implemented a streamlined claims processing system;
- identify barriers and problems that need to be addressed to implement a single claims processing system or to streamline the current claims processing system;
- determine resources necessary to implement a single claims processing system or a streamlined system and develop a model for a single claims processing system;
- determine the impact on health care providers and health insurance carriers in a single claims processing system or a streamlined system; and
- identify the necessary steps for protecting the confidentiality of medical records and proprietary information in a single claims processing system or a streamlined system.

Structure of the Current System

Nationally, the health insurance industry processes almost 5 billion medical claims a year based on estimates from the Health Insurance Association of America, an industry trade group. Claims processing is described by many as including both front-end and back-end processing. Front end processing happens as the health care provider prepares the claim, verifies eligibility and authorizations and submits the health insurance claim. Once the claim is submitted, the back-end processing occurs as the payor receives, adjudicates and pays the claims.

Figure 1. Overview of Claims Processing

FRONT-END PROCESSING: ***Health Care Provider Prepares and Submits Claim***	**BACK-END PROCESSING:** ***Payor Receives, Adjudicates and Pays claim***
1. Identify health care services provided 2. Cost charges • Collect charge information • Batch charges • Edit charges • Data entry • File copy 3. Code charges • Group coding • Diagnosis coding • Edit coding 4. Match patient bill with appropriate payor or bill patient if no third-party payor responsible for charges 5. Create claim • Add substantiating documentation • Select form of claim submission (paper or electronic) • Complete claim form with attachments • Edit and correct • Create bill • File copy 6. Transmit claim to third-party payor • Prepare to send (paper or electronic) • Transmit claim • Track receipt of claim by payor • Correct if claim denied and resubmit • Bill patient for denied services or for balance due	1. Payor receives claim • Open claim • Sort claim (paper or electronic) 2. Prepare claim for permanent storage • Batch claims • Microfilm claims 3. Data entry of claims or scan claims 4. Edit claims • Return to provider if edits not passed • "Clean" claims accepted 5. Adjudicate claim • Determine patient eligibility • Determine provider eligibility • Determine service level edits • Determine payments and liabilities 6. Pay claim • Create actual payment (check) • Create remittance advice for provider • Create explanation of benefits for patient 7. Maintain data record of claim

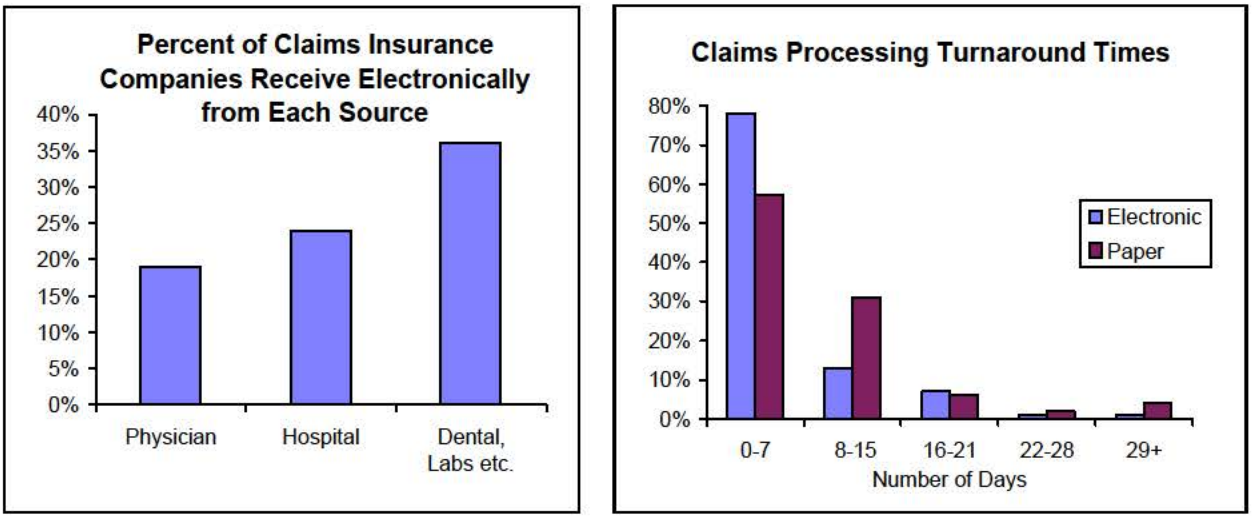
Standardization of claim forms targets the simplification of front-end of claims processing. Under current Maine law, all licensed hospitals and licensed physicians and chiropractors who bill for health care services must use the current standardized claim form approved by the Federal Government (see MRSA 24 § 2985). Similarly, all nonprofit hospital and medical service organizations, e.g., Blue Cross and Blue Shield, commercial health insurers and health maintenance organizations licensed to do business in the State are required to accept the standardized claim form approved by the Federal Government (see 24 MRSA § 2332-E; 24-A MRSA § 2753; and 24-A MRSA § 4235). There are two commonly used claim forms approved by the Federal Government. The HCFA-1500 claim form is used primarily for billing health care professional services. The UB-92 claim form is used for billing institutional services, including the services of hospitals and rural health clinics.

Payors for the most part have invested a significant amount of money and effort into developing their claims processing and adjudication systems. In the current health insurance marketplace, payors use four market differentiators to compete: benefit design, networks, contracts and electronic capabilities. Each of these factors must be programmed into their individual

adjudication systems. For this reason, many payors resist proposals to remove their control over the back-end of the process of adjudicating and paying claims.

Electronic claims processing has been a significant advance in claims processing. Claim forms still must be filled out by providers, but instead of having to mail forms or create a computer tape of the claims, the provider can submit claims to payors over telephone lines via a modem. Electronic claims submission simplifies the process for providers and payors. Providers spend less time sending claims back and forth to payors and payors receive claims in a format that is easy to verify and process. The number of providers and payors using electronic claims processing in the health care industry continues to grow as the technology becomes more accessible throughout the industry. When the Health Insurance Association of America first surveyed its insurance company members in 1990 on the status of electronic claims processing, only 2% of hospital claims and 1% of physician claims were being processed electronically. In 1995, the percentages had risen to 24% of total claims: 24% were hospital claims; 19% were physician claims; and 36% were other claims. (Figure 2 below)

Figure 2: Electronic Claims Processing



Source: Health Insurance Association of America, "Insurance Company Coding and Claims Systems: A Survey," July 1996. 53 of 120 companies responded to the survey. Respondents represented approximately 30% of commercial insurers' health insurance business and processed an estimated 320 million claims in 1995.

Claims Clearinghouses

A claims clearinghouse is a centralized service available to health care providers to consolidate billing for medical claims across multiple payors. Often, clearinghouses perform value-added services like editing of data for validity and accuracy and translating data from one format to another, e.g. electronic to paper. The Health Insurance Portability and Accountability Act defines a health care clearinghouse as "a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements."

There are a number of private sector claims clearinghouses available to health care providers and payors that facilitate electronic and paper claims processing. The clearinghouse acts as a simple point of entry for electronic claims from providers and the clearinghouse routes claims to the appropriate third-party payor. Payors also can act as clearinghouses for claims of other payors.

Problems Faced in the Current System

National estimates indicate that administrative costs for claims processing and other activities account for 26 cents of every dollar spent on health care. A New York State study suggests that between 20 and 40 percent of administrative costs can be attributed to processing of claims, but what portion of that estimate is directly attributable to claims processing costs is unknown. Efforts at administrative simplification are aimed at reducing the administrative burdens on all of the participants in the health care delivery system: patients, providers and payors. While the health care industry suggests that close to $9 billion dollars annually can be saved in administrative costs through simplification, it is unclear how much savings these efforts would bring to Maine's claims processing system.

Filling out claim forms can be a time consuming and complicated task, particularly for smaller providers. Once the claim form is filled out, billing staff must also follow up on questions and requests for more information from payors. In particular, questions on coordination of benefits, determining which payors are responsible for what portion of the bill, require additional attention from billing staff. Simplification and standardization of claims forms would lessen the amount of time providers need to spend filling out, filing and following up on claims.

Under the health care delivery system, third-party payors of health care benefits use multiple claims processing systems. The requirements of each system for the processing of health care claims creates administrative and technical difficulties for both health care providers and medical billing professionals. While generally, there are two standard claim forms used by third-party payors, the HCFA-1500 form used to bill professional services and the UB-92 form used to bill institutional services, the data field requirements of payors often differ. Despite the use of a standard form, health care professionals and providers must complete the form differently depending on the third-party payor processing the claim for reimbursement.

Another problem experienced by many providers and smaller third-party payors is lack of electronic claims processing capability. With advances in computer technology over the last two decades, electronic claims processing has been explored as a means of streamlining and simplifying claims processing. However, many health care professionals do not have computerized medical records and billing services. This lack of access throughout the state presents a significant barrier to a streamlined processing system.

Among payors, many do have the ability to accept a significant amount of claims electronically, either directly or through a clearinghouse. The State's Medicaid program processes a large percentage of its claims electronically. Blue Cross and Blue Shield of Maine also has electronic claims capability along with Healthsource Maine and Harvard Pilgrim Health Care. Some third-party payors, especially some smaller companies, lack the in-house capability to accept electronic

claims. For instance, NYL Care of Maine, a larger health maintenance organization, cannot currently process electronic claims, although the company expects to implement that capability very soon. Many third-party administrators and workers' compensation carriers also lack electronic capability for processing medical claims.

Even if a provider has the ability to transmit claims electronically, different data standards are another barrier to increasing the use of electronic claims transmission. This means, in some instances, that even though a provider has the ability to transmit claims electronically, that provider does not because the payor uses a different data standard. For example, one data standard might record the date with the month first, the day second and the year last. However, another standard might record the information with the year first, followed by the month and then the day. The different number of data standards also makes it more difficult to use information on the claim form to track types of illness, care and treatment. In a Health Insurance Association of America survey of insurance companies, 79 percent of respondents accepted ANSI standards (see below), 31 percent accepted National Electronic Information Corporation standards, 14 percent used other standards and 48 percent had proprietary systems (note: sum of numbers does not equal 100 percent because companies may accept more than one standard).

Health Care Transaction Simplification on the Federal Level

Health Insurance Portability and Accountability Act Administrative Simplification Provisions

The Health Insurance Portability and Accountability Act ("HIPAA") was enacted by Congress on August 21, 1996. While HIPAA may be better known for implementing portability requirements for individual and group health insurance plans, the Act also contains provisions aimed at administrative simplification to reduce the administrative costs and burdens in the health care industry.

HIPAA requires the Department of Health and Human Services ("HHS") to adopt uniform national standards for the electronic transmission of any health care information. While HIPAA does not require that certain health information, e.g. health insurance claims, be filed and processed electronically, it does require standards be in place for the electronic transmission of the following types of information:

- health claims or equivalent encounter information
- coordination of benefits
- enrollment and disenrollment in health plans
- eligibility for a health plan
- health care payment and remittance advice
- health care plan premium payments
- health care claims status
- referral certification and authorization
- first report of injury
- claims attachments

In addition, the law requires that confidentiality protections be put in place for information processed in accordance with the new standards developed by HHS. HHS is also required to make recommendations to Congress for legislation relating to health record privacy. If Congress fails to adopt such legislation, then health care providers, health plans and health care clearinghouses would be required to follow confidentiality regulations established by HHS in the electronic transmission of health care information.

HIPAA requires that the standards for electronic transmission of health information apply to providers, including professionals, hospitals and other institutional facilities; payors, including Medicare, Medicaid and private payors; and health care claims clearinghouses contracted by providers and payors to electronically receive and process health information.

These standards must be adopted by HHS by February 1998 (standards for claims attachments are not required until February 1999) and implemented by health plans in February 2000, except small group health plans who have an additional year. After February 2000, payors must accept standard claims when submitted electronically and may not require providers to make changes or additions to standard claims other than approved attachments. Payors that refuse the standard transaction or delay payment would be subject to penalty. The requirements for standard transactions may be satisfied by submitting non-standard data to claims clearinghouses for processing and electronic transmission into a standard format or by receiving standard data elements from a clearinghouse.

American National Standards Institute ("ANSI") Standards

The American National Standards Institute is a national organization founded in 1918 that develops the national standards system for the United States. The institute formed a committee in 1979 called ANSI X12 to develop consensus standards for electronic data interchange and transfer of information. A subcommittee - ANSI X12N - was formed to develop electronic data interchange standards in the insurance industry, including health insurance. The ANSI committees and subcommittees include representatives from government and the private sector. These efforts at standardizing electronic data interchange in the health insurance industry have been recognized in HIPAA. HIPAA requires that the standards adopted for electronic transmission of health information be standards developed, modified or adopted by an ANSI accredited standard setting organization. Standards that differ from ANSI standards are permissible only if no standard is already in place or if a different standard will substantially reduce administrative burden to providers and health plans compared to the alternatives.

National Uniform Billing Committee

The National Uniform Billing Committee ("NUBC") was formed as a voluntary organization of payors, providers and interested parties to establish data standards for the Uniform Bill Form-92. The NUBC brings together representatives from national provider and payor organizations within the health care industry for the purpose of developing, maintaining and promoting a uniform standard data set and format to be used by institutional providers for the exchange of claims related information within health care. The NUBC oversees the UB-92 data set definitions and

specifications for both paper and electronic applications. NUBC members are committed to achieving efficient national use and acceptance of the UB-92 data set among institutional providers and health care insurers. The NUBC maintains a complete list of allowable data elements and codes. Each state is encouraged to develop its own State Uniform Billing Committee ("SUBC") to work on state specific codes and fields. (See Health Care Transaction Simplification in Maine.)

National Uniform Claim Committee

Another group recently formed based on the NUBC is the National Uniform Claim Committee ("NUCC"). The National Uniform Claim Committee was organized in May 1995 to develop, promote, and maintain a standard data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payors. The data set includes data elements, definitions, and code sets. The NUCC is chaired by the American Medical Association with the Health Care Financing Administration as a critical partner. The Committee includes representation from key provider and payor organizations, as well as standards setting organizations, state and federal regulators, and the NUBC.

Health Care Transaction Simplification in Other States

With the introduction of President Clinton's health care plan in the early 1990s, private, non-profit and governmental agencies began examining ways to reduce health care costs in general. One target of this movement was administrative simplification. Several states set up studies and examined ways to ease administrative burdens on providers and reduce costs of health insurance. The Task Force identified several efforts that were focused on simplification of claims processing. These include: New York, New Jersey, Maryland, Minnesota, Colorado, and Utah. Included below is a brief description of the goal and results of the programs implemented in these states.

New York

In 1990, New York received a grant from the Robert Wood Johnson Foundation to facilitate the electronic submission of hospital claims to private insurers and other payors. The program was originally titled, "Single Payer Demonstration Program," but was changed to an electronic claims clearinghouse program. Under this pilot program, New York selected two companies (CIS, Inc. and Wellmark, Inc.) through an RFP process to provide clearinghouse services for the demonstration program. The two clearinghouses were responsible for "clearing," taking electronic information from one format to another, and "clean claiming," checking data fields, before transferring them to the appropriate payors. Twenty-seven hospitals participated in the project.

The first phase of the project was to implement an electronic claims submission system for all payors. The second phase of the project was to create a point-of-service eligibility file that allows providers to determine a patient's enrollment in an insurance plan at the time service is provided. The final phase was to implement electronic claims submission statewide.

Capital costs for the demonstration project were approximately $59,000 for a 250-bed hospital. Annual operating costs were estimated at $56,000 for a typical 250-bed hospital. The capital costs were funded with the grant money, while annual operating costs were borne by the hospitals. The clearinghouses charged the hospitals directly for processing claims. For inpatient claims, CIS, Inc. charged a fixed amount per month based on the number of beds, while Wellmark charged on a transaction basis. Both clearinghouses charged a per transaction fee for outpatient claims.

In New York, there was a significant increase in the percentage of claims submitted electronically by the participating hospitals. For inpatient claims, 2% were submitted electronically before program compared with 88% during program. The number of days between date of service and resolution for inpatient claims decreased from 67 days before program to 53 days after implementation, while the number of days between date of service and resolution for outpatient claims decreased from 83 days before program to 56 days after implementation. Even with the success of the program, it did not continue past 1994 when the funding for the project ended. However, New York did continue to focus on administrative simplification through legislation.

The New York Legislature passed a law in 1993 that requires hospitals, diagnostic and treatment centers, ambulatory surgery centers and physician services to submit claims for payment to third-party payors electronically. To implement this legislation, the Uniform Universal Claims task force was established to create a billing standard for institutional providers. A second task force, Physician Claims task force, was established to develop standard billing forms for physicians (MD and DO). New York is unique in some respects because state specific claim forms are used. The requirements for submitting claims electronically were phased in over a four year period beginning with inpatients for general hospital services in 1994, then outpatients in 1995. Blue Cross and Blue Shield physicians began submitting claims electronically in October 1996 and all other physicians started in the spring 1997. Under the law, the commissioner can delay or waive the requirements for settings that have a small volume of business (less than 3,600 claims annually).

During the transition period for the physicians, the Department of Health offered presentations to interested physicians which included: the intent of the law, an explanation of the technical aspects, an explanation of the practical aspects, and a primer on hardware requirements.

New Jersey

Healthcare Information Networks and Technologies (“HINT”) was created by the 1994 New Jersey Legislature to investigate available information technologies possessing cost savings potential for health care. The report included a technological and socio-economic analysis of the current state of technology, improvements available and barriers to implementation. Working out of the New Jersey Institute of Technology, HINT still serves as a resource to the legislature and is working on a report about Community Health Information Network implementations.

HINT conducted a mail survey to determine the current state of technology. The HINT mail survey had a 34 percent response rate (407 respondents). The 1,248 surveys were mailed to the following seven sample groups: physicians, hospitals - claims processing, hospitals - medical

records, labs, employers, pharmacies, insurance companies, and payors (which included third party administrators and health maintenance organizations).

Table 1: Claims Processing Method by Sample Group

	Physicians	Hospitals	Labs	Pharmacies	Payors
Average # Claims Processed Per Week	109	600	314	418	130
Methods Used:					
Paper Only	62%	14%	47%	-	63%
Electronically Only	-	-	2%	43%	-
Both Paper and Electronically	36%	81%	47%	57%	38%

Table 2: Cost to Process Paper vs. Electronic Claims In-House by Sample Group

	Physicians	Hospitals	Labs	Pharmacies	Payors
Average # Staff Hours Per Week					
Paper	18	116	37	9	109
Electronic	15	82	54	32	15
Average Cost per Claim					
Paper	$4.29	$4.50	$3.75	$3.84	$5.40
Electronic	$2.79	$3.83	$2.35	$2.90	$3.42
$ Difference	$1.50	$0.67	$1.40	$0.94	$1.98
% Less for Electronic	35%	15%	37%	24%	37%

Table 3: Average Rejection Rates for Initial and Follow-up Claims by Sample Group

	Physicians	Hospitals	Labs	Pharmacies	Payors
Average Rejection Rate for Initial Claims:					
Paper	14%	17%	15%	11%	13%
Electronic	11%	9%	10%	9%	9%
% Less for Electronic	21%	47%	33%	18%	31%
Average Rejection rate for Follow-up Claims:					
Paper	10%	11%	9%	8%	9%
Electronic	8%	6%	7%	6%	5%
% Less for Electronic	20%	45%	22%	25%	44%

Table 4: Average Age (in Days) of Accounts Receivable by Sample Group

	Physicians	Hospitals	Labs	Pharmacies
Paper	58	66	52	50
Electronic	28	37	32	24
% Less for Electronic	52%	44%	38%	52%

Table 5: Claims Transaction Attachments Required by Sample Group

	Physicians	Hospitals	Labs	Pharmacies	Payors
% Reporting that Less than 25% of Claims Required Attachments	65%	67%	68%	93%	46%
% By Reason for Attachment:					
Insurance Company	84%	67%	75%	76%	70%
Law/Reg.	5%	29%	15%	16%	14%
Other	11%	4%	9%	9%	16%

Table 6: Level of Computerization Among Sample Groups

	Physicians	Hospitals	Labs	Pharmacies
% Currently using a computerized system	33%	59%	40%	89%

Maryland

In 1993, Maryland introduced legislation that required all providers to begin transmitting claims electronically by July 1, 1995. Prior to implementation, Maryland contracted with Gallup to determine if providers were able to transmit claims electronically, both with the hardware/software capacity and knowledge of systems. Gallup found that although most providers had computer systems, providers did not have the knowledge to submit claims electronically. The Legislature repealed the start date of the mandate and decided to pursue electronic claims filing another way.

Now Maryland has a voluntary certification program for electronic health networks (clearinghouses). The way the legislation is written Maryland could select one clearinghouse to process all the claims in the state, but the state decided to see how the system functioned with a competitive market. The Electronic Health Network Accreditation Committee ("EHNAC"), a private group based in Connecticut, runs the certification program. Once a clearinghouse has been certified by EHNAC, it can apply to Maryland to be certified in the state.

The incentive for clearinghouses to be certified is that all payors with more than $1 million in premiums (approximately 60-70 companies) must contract with at least one certified

clearinghouse in order to allow the payor to accept claims electronically. Providers are not required to submit claims electronically, although some payors have begun to add a surcharge to process paper claims. Payors are also required to submit to the State an annual report on the their status regarding electronic claims processing.

Generally, the EHNAC certification process takes about six months to complete. It begins with an initial application, followed by a self-assessment by the company. The four major areas of examination are: privacy and confidentiality, technical performance, business practices and resources. EHNAC reviews the self-assessment and then conducts a site visit to verify the information provided and conduct a thorough examination. The cost of certification ranges from $5,500 to $8,500, depending on the size of the company. Companies are recertified after two years. There are currently seven clearinghouses certified by ENHAC, with two more applications pending. The seven certified companies are: The Halley Exchange, Inc., Synaptek (division of ENOY-NEIC), CIS Technologies, Inc., HBO & Company (Electronic Commerce Group), Professional Office Systems, Inc., Maryland Health Information Network, and Blue Cross and Blue Shield of South Carolina.

Maryland stressed that the government is trying to help establish the infrastructure for electronic claims transmission at the payor level with the intent that the payors will help educate providers on the potential benefits of electronic data interchange. Providers seem to need the most education and are the most resistant to these changes because it does often involve assessing business practices and structures.

Minnesota

In 1994, the Minnesota Legislature passed the Health Care Administrative Simplification Act which included provisions covering electronic data interchange use and standards. Under the provisions of the law, group purchasers, health care providers and employers are not required to use electronic data interchange. However, participants in the health care system who use electronic billing, enrollment or eligibility transactions must support the ANSI ASC X12 standards.

The Commissioner of Health was required to administer the implementation of and monitor compliance with electronic data interchange standards of health care participants. In 1996, the Commissioner adopted a Minnesota-specific implementation guideline for using ANSI ASC X12 837 version 3051 standards..

The Act also created the Minnesota Center for Health Care Electronic Data Interchange to facilitate the statewide implementation of electronic data interchange standards in the health care industry. The mission of the center is to empower health care organizations to make informed decisions relative to electronic data interchange (“EDI”) by providing timely, relevant, unbiased, quality education and resources to speed the rate and improve the effectiveness of implementing EDI in Minnesota and the nation. The center provides health care EDI courses, facilitates the adoption of standards for health care EDI transactions, and provides information on EDI and electronic commerce through their resource center.

Colorado

In 1993, the Colorado Health Electronic Data Interchange Advisory Board ("CHEDIAB") was created to encourage the development and implementation of a comprehensive, uniform electronic system for billing and paying claims and exchanging related information among health care providers, health care carriers, third-party payors, and employees. This board was established for a five-year time period and is scheduled to dissolve July 1, 1998. The board is comprised of consumers, providers, insurers and other payors, regulators and employers. The number of people participating has grown from 9 board members to approximately 100 participants.

CHEDIAB determined it would not develop legislation to implement EDI. In their assessment, market forces and federal initiatives are leading the process. Any EDI guidelines should be implemented on a federal level so that different states do not develop conflicting standards. The group is currently monitoring national developments in EDI, educating providers/payors on the benefits of EDI, and encouraging use of standards for EDI. The final report of CHEDIAB should be available early 1998.

Utah

The Utah Health Information Network ("UHIN") began in 1990 as a coalition of payors, providers and government to reduce the costs of health care. In 1993, it became a public/private non-profit entity. Currently, UHIN runs a statewide network of claims transmission and remittances. One of the reasons the network has become viable and is working well is that UHIN came up with one standard claim form and data set. The result is that the data on the form means the same thing to everyone on the network. Providers dial into the system and can upload their claim forms and download remittances from their own mailboxes. Large payors have established a direct line to the network and check their mail boxes every few minutes to collect claims.

At this time, UHIN estimates that 95% of all providers (including Medicaid and Medicare, doctors, midwives etc.) in the state are on the system. Approximately 70% of all claims in the state go through the UHIN system. The remaining 30% are federal employee plans and national payors. Members of the Utah Medical Association pay an annual fee to be part of the network (see table below).

Number of Licensed Medical Providers	Annual Cost
1	$100
2 to 9	$200
10 to 24 or a small hospital	$450
25 to 49 or a medium hospital	$2,000
50 or more or a large hospital	$5,000

UHIN also sells software for $50 that edits claims and works with practice management software translators. UHIN provides training to help providers learn how to use the software and the

system. Payors are charged $0.20 for each claim received, while providers are charged for each remittance they receive ($15.00 per month or $0.12 per remittance).

UHIN's success relies on the fact that the group came together voluntarily to establish this system and each member of the board (there are 19 members) has the ability to veto a decision, policy or standard. With this system, everyone has an equal say in the decision-making process. Each member of the board also provided the initial funding to get the project going.

Health Care Transaction Simplification in Maine

Maine Community Health Information Network

Development
In 1994, following a presentation from IBM on Vermont's efforts to receive funding for a Community Health Information Network ("CHIN"), several hospitals in southern and central Maine developed a plan for a CHIN in Maine. After some initial research, the Maine Community Health Information Network Policy Board was founded in early 1995. This group included: Maine Hospital Association, Healthsource Maine, Maine Medical Association, Blue Cross and Blue Shield of Maine, Maine Medical Assessment Foundation, Maine Health Management Coalition, Maine Department of Human Services and Maine Osteopathic Association. The mission statement developed by the CHIN is:

> Supporting providers and payors managing care at the community level through the development of an efficient and compatible statewide health information network to meet the community's shared health care needs in assessing and planning for the improvement in the health care status of community members.

Planning
In 1995, there was very little information available about the use of technology by the hospitals and doctors in Maine. In response, the Maine CHIN conducted an assessment to gather some of this information. The CHIN surveyed Maine hospitals and doctors to determine their system configurations and future technology plans. With a better picture of the current use of technology and the expectations for the future, the Maine CHIN was able to tailor the final outcome to match the capabilities of hospitals and doctors.

During the past two years, the Maine CHIN has been working on three goals: 1) proposing system specifications for review and comment by the health care community; 2) negotiating vendor relationships and 3) developing a business plan that supports the community's interest. In order to reach these goals, the Policy Board organized three committees, Administrative, Clinical, and Information Systems, to examine specific aspects of the CHIN. Each committee determined what features it would like to see available in the CHIN network. Once all the features were collected, the Policy Board decided which features were feasible and in what order they would be implemented. In the first phase of the CHIN implementation, the features available are expected to include:

Administration
Patient Demographics
Claims submission/Processing
Claims Status
Electronic Remittance Advice/Posting
All Payor Eligibility
Treatment Preauthorization/UR Certification
Referrals/Referral Authorization
Electronic Panel Reports (managed care)
Electronic Capitation Reports (managed care)

Network
Data/File Sharing
Email
Security/Privacy
Internet Access

Clinical
Master Patient Index
Test Results
Patient History

Implementation
At this point, the Maine CHIN is preparing to implement phase I of the network at pilot sites in early 1998. During phase I, the Maine CHIN will act as a claims clearinghouse for all participants in the network. Using an intranet, a private network, each participant will have access to the Maine CHIN through a common web-type interface. A common interface simplifies the claims entering process because the look of the form will be the same for all payors. Once the claims have been entered by the provider, the claims are transmitted to the clearinghouse. The Maine CHIN, through the clearinghouse, will edit the claims to assure that the information has been entered in the proper format. Then, the clearinghouse will split the claims according to the payor and make any edits specified by the payor. Finally, the clearinghouse will send the claims to each of the payors and provide the original participant who submitted the claims a report of how many claims went to each of the payors.

The Maine CHIN has not yet established rates for the use of the network. During the implementation of phase I, the pilot sites will not be charged for the use of the network, as they are volunteering to help work out the kinks of the system. As phase I proceeds, the Maine CHIN will be able to figure out the true costs and benefits to using the system and then develop a pricing structure accordingly.

Privacy and Confidentiality
Another area of concern when dealing with a network of many providers and payors is confidentiality and privacy. In January 1996, the Maine CHIN developed a Confidentiality committee to address these issues. The committee discussed the impact of network functions on confidentiality, privacy and security. After thorough discussions, the group developed recommendations for ensuring privacy of the information traveling via the network. One important distinction with the Maine CHIN is that it is not a repository or warehouse of health data, it is only a network by which this information travels. The Policy Board is currently examining the recommendations submitted by the Committee to establish the Maine CHIN's privacy, confidentiality and security policies.

Financial Implications

The Maine CHIN did not enter into this process thinking only about the technological implications. Clearly, the concept will not be successful unless it can be provided at a reasonable cost. The Maine CHIN contracted with Ernst & Young to determine what business value health systems, payors and physicians will derive from a statewide CHIN and whether there is a business case for the creation of a statewide CHIN. The study determined that all of the stakeholders (providers, hospitals and payors) would have a cost savings within three years.

Future Plans

The long range plans for the Maine CHIN involve more than simply acting as a clearinghouse, but as a means for simplified access and sharing of clinical information. Using the infrastructure developed for the administrative functions, medical professionals will be able to transmit clinical and diagnostic information. Even more significant cost savings will be achieved at this point, when doctors in different parts of the state can share information and opinions on a patient's condition. Sharing of clinical information would have a large positive impact in rural areas where access to specialized medical care is limited. One of the objectives of the Maine CHIN is to facilitate the development of administrative, clinical and lifetime patient record databases. Some of the functions that the Maine CHIN envisions providing during the second and third phases are:

- Clinical Test Order Entry
- Telemedicine
- Medical Record Access
- Online Pharmacy Access
- Computer Assisted Diagnosis
- Electronic Signature and Physician Attestation
- Transcribed Reports and Discharges

Clearinghouse Options in Maine

There are several clearinghouse options for providers in Maine. National clearinghouses, such as Envoy-NEIC and MedE America, offer connections with thousands of payors. These companies specialize in providing easy entry and access to their clearinghouse systems. A provider in Maine could contract with one of these clearinghouses to transmit their claims to the appropriate payors. A second option is the use of Blue Cross and Blue Shield of Maine's all payor system. This system provides a simple, single point of submission for providers to submit all payor claims electronically. Once Blue Cross and Blue Shield receives the claims, they are edited, reformatted and electronically transmitted to the appropriate payor. The Blue Cross and Blue Shield system transmits claims directly to many of the larger payors (for example, Medicaid, Medicare Part A, Medicare Part B) and also transmits to other clearinghouses such as EDI-USA and NEIC. If a payor does not have electronic capability, the electronic claim is printed to a claim form and mailed to that payor. During a recent upgrade of the clearinghouse system, Blue Cross and Blue Shield temporarily suspended the addition of new users to the all payor system. During this period, new users were supported for the submission of Blue Cross and Blues Shield, Medicare Part A and commercial payor claims. The upgrade of the all payor system is currently complete and existing users are in the process of being converted to the new system. The all payor system will be available to new users during the first quarter of 1998.

State Uniform Billing Committee

The State Uniform Billing Committee ("SUBC") functions in the same way as the National Uniform Billing Committee, but on a local level (see Health Care Transaction Simplification on the Federal Level). The Maine SUBC was formed in August 1992 when a subcommittee of the Maine Association of Patient Account Managers voted to become a state uniform bill committee. The members of the SUBC include representatives of hospitals, third-party payors, and medical billing and claims professionals. Representatives of the Bureau of Insurance and the Workers' Compensation Board also participate.

The main purpose of the SUBC includes reviewing and coordinating statewide adherence by providers and payors to the national UB-92 data set and hard copy billing format and maintaining a state uniform billing procedure manual. The SUBC is responsible for defining and controlling statewide assignment and use of undefined data fields and local use coding ranges. If a payor wants to add a code to the data set, the payor must submit a request to the SUBC. The committee will consider the request and determine if it is an appropriate use of the specific field. If it is a significant or national change, the SUBC will send the request to the NUBC for further review. Otherwise, the state uniform bill committee will examine the request and it will be accepted or rejected. If the request is accepted, then a change is made to the state data set and state billing procedure manual.

The SUBC is not a state agency or department. It functions as a completely independent organization. The benefit of this is that the committee can make decisions based on the needs of the payor and provider communities. The drawback is that the committee has no authority to require payors and providers to use their data set. If payors want to require the use of a code that is not sanctioned by the SUBC, they can do so without penalty.

Maine Health Data Organization

The Maine Health Data Organization ("MHDO") was established by the Legislature on May 1, 1996 and became operational on December 31,1996. The MHDO is an independent state agency charged with creating and maintaining a health information data base for the State. The MHDO is the successor for the clinical and financial databases administered by the Maine Health Care Finance Commission. One of the primary purposes of the MHDO is to establish uniform reporting systems for the collection, processing, storage and analysis of clinical and financial health data. The MHDO has the authority to require the filing of inpatient, outpatient and ambulatory services data from health care facilities, including hospitals, home health care providers, community rehabilitation programs, mental health facilities and hospice providers; health care practitioners; and payors. Although MHDO does use its own forms to require the reporting of some health care data, a primary source for reporting the data is the UB-92 claim form. Efforts at standardizing health claim forms and claims data and technological advances in the processing of health claims directly impacts the collection and processing of health data by the MHDO.

Findings and Recommendations

The Task Force declines to develop a model for a single claims processing system for the State.

Although one of the charges of the Task Force was to develop a model for a single claims processing system, the Task Force does not recommend a model for a single claims processing system. The task of developing such a model is a difficult one given the complexities of the health care delivery system and the wide range of participants in the system: patient, provider and payor. The time and resources needed to develop a single claims processing system are significant and beyond the limited time frame and resources of the Task Force. Further, in examining the current system in Maine and the efforts made in other states to develop a single claims system model, the Task Force concludes that an incremental approach is the appropriate means for addressing the issue of claims processing at the state level. Therefore, the focus of the Task Force's findings and recommendations address the current claims processing system used by providers and payors in the State, the problems associated with the system, and efforts to improve the system at the state and national level.

The Task Force does not support a state-mandated single claims processing system or state laws requiring the electronic submission or acceptance of health insurance claims.

The Task Force believes that it is not appropriate for the State to develop and implement a state-wide single claims processing system for third-party payors of health care benefits. The Task Force also does not recommend the passage of legislation requiring providers to submit electronic claims or for payors to have electronic claims processing capabilities. At this time, the Task Force recommends that the private sector take the lead role in developing these efforts among providers and payors on a voluntary basis. The efforts to improve and simplify the system outlined in the body of the report are very promising indications that the private sector will succeed. While the Task Force supports the concepts embodied in a single claims processing system and in electronic claims processing, it believes market forces will demand that payors develop and implement electronic claims processing systems either in-house or under contract with private claims clearinghouse or other vendors.

The Task Force recommends that efforts at improving the current claims processing system focus on front-end processing to assist health care providers by building on the existing and emerging infrastructure, expertise and technology throughout the State.

In examining the current claims processing system and the problems associated with it, the Task Force has determined that health care providers are experiencing the greatest problems with the system compared with payors. Many providers and billing professionals are having difficulties in meeting the requirements of different payors because of the complexities of the delivery system. Payors, on the other hand, have generally been able to keep up with the advances and changes in the delivery system and indeed have been a major part of those changes. Payors use their claims processing systems, especially their adjudication systems and electronic claims capability, as market differentiators to compete in the marketplace against other payors. For that reason, the

Task Force believes efforts at improvement should focus on front-end processing rather than back-end processing. In looking at improvements to the system, however, the Task Force recommends strongly that the system build on the existing infrastructure and technology and the emerging developments being driven by the private sector to make any change or transition to a more efficient and simpler claims processing system as smooth as possible for providers.

The Task Force finds that market forces and cost savings will create the incentives to participate in private sector health information networks and claims clearinghouses as a means for providers and payors to reduce the administrative burdens of claims processing.

Given the rapidly changing and competitive health care marketplace, the Task Force finds that market forces will be the greatest motivator for providers and payors to take part in private health information networks or claims clearinghouses and to develop electronic claims submission and processing capability. If the network, clearinghouse or electronic claims capability can demonstrate cost savings and efficiencies for providers and payors, the Task Force believes the value of these improvements will demand participation. The data examined by the Task Force indicates that electronic claims processing especially can achieve significant efficiencies for both providers and payors. Once these efficiencies are demonstrated, providers and payors in the State will not be able to ignore the opportunity to reduce the administrative burdens of claims processing.

The Task Force recommends that providers and payors should be encouraged to use technology to access private health information networks or claims clearinghouses to simplify the submission of claims.

In looking at the current claims processing system, the Task Force concludes that electronic transmission of health information, including claims, is the future. Current and emerging developments like claims clearinghouses and private health information networks are ways that providers will be able to access the system and submit claims electronically. The only significant barrier for providers is access to that technology. Accordingly, the Task Force recommends that providers and payors should be encouraged to use this technology. The technology must be developed for providers in such a manner as to allow providers a point-of-entry into the electronic claims processing system either directly or through a network or clearinghouse. To simplify the submission of claims for providers, the claim must be able to be transmitted by the provider in any format. The conversion of the claim information into the format required by the provider should be done by the network or claims clearinghouse.

The Task Force finds that government efforts to encourage continuing development of technology and standardization of claims processing and health information are being undertaken currently at the federal level through the passage and implementation of the Health Insurance Portability and Accountability Act's administrative simplification provisions. The role of state government in improving the claims processing system should be reevaluated after the federal laws and regulations are adopted and implemented.

As required by the Health Insurance Portability and Accountability Act, the federal government is currently going through the process of establishing standards for the electronic transfer of health information, including claims information and attachments required by payors. The adoption and implementation of these standards should be complete by early 2000. Since the federal government has taken an active role and the federal standards once developed will apply nationally to all providers and payors, the Task Force believes that any role of state government in developing public policy should be suspended and reevaluated at a later date, after the federal standards are in place.

The Task Force finds that the issues related to the confidentiality of health information in an environment of electronic claims processing, single claims processing system or private health information network are being addressed adequately.

The Task Force has examined the issue of confidentiality of health information in the current claims processing system, including the electronic submission and processing of claims, and believes the issue is being adequately addressed. The Health Insurance Portability and Accountability Act of 1996 required the Department of Human Services to develop and make recommendations for legislation governing the confidentiality of health information in an increasingly electronic age. The department made its recommendations in the fall 1997 to Congress. Under HIPAA, Congress has until August 1998 to enact legislation on this issue. If legislation is not enacted, HHS must adopt confidentiality regulations by February 1999. Further, the issue of confidentiality is being debated in the Maine Legislature currently with two legislative proposals undergoing review by the Joint Standing Committee on Health and Human Services. Similarly, confidentiality policies and procedures are being carefully developed for use by the private health information network being established in Maine.

The Task Force recommends that legislation be introduced in the First Regular Session of the 119th Legislature to reconvene a study of the current claims processing system to monitor the development of standards for electronic claims processing and the efforts in the private sector at improving the system.

Although the Task Force has not recommended any specific legislative initiatives related to improvements in the claims processing system, it strongly believes that the Legislature should establish a task force or conduct a study by January 1, 2000. This study should monitor the implementation of the standards required by the Health Insurance Portability and Accountability Act regarding standards for the electronic transmission of health information, including claims, and the development and level of electronic claims capability by both providers and payors through claims clearinghouses or private health information networks. At that time, the Task Force believes it is important to evaluate the federal standards and the status of the claims processing system in the State and to address whether or not legislative initiatives are needed and whether or not state government should have a more direct role in this area.

Appendices

Appendix A: Legislation Establishing the Task Force to Study the Feasibility of a Single Claims Processing System for Third-Party Payors of Health Care Benefits

Resolve 1997, chapter 63

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, in current practice, 3rd-party payors of health care benefits use multiple claims processing systems; and

Whereas, other jurisdictions have begun exploring the feasibility of implementing a single claims processing system for all 3rd-party payors and are also exploring ways to streamline claims processing; and

Whereas, it is necessary to begin the study of the feasibility of a single claims processing system or a more streamlined system for 3rd-party payors of health care benefits in this State; and

Whereas, the members of the task force established by this resolve must be appointed prior to the expiration of the 90-day period; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force established. Resolved: That the Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-party Payors of Health Care Benefits, referred to in this resolve as the "task force," is established to study the feasibility of a streamlined claims processing system for 3rd-party payors of health care benefits and to study the feasibility of a single claims processing system for 3rd-party payors of health care benefits; and be it further

Sec. 2. Task force membership. Resolved: That the task force consists of 15 members appointed as follows:

1. One representative of the Maine Medical Association or the Maine Osteopathic Association appointed by the Governor;

2. One Maine-based representative of the Health Insurance Association of America appointed by the Governor;

3. One representative of Blue Cross and Blue Shield of Maine appointed by the Governor;

4. One representative of the Home Care Alliance of Maine appointed by the Governor;

5. One representative of the interests of independent occupational, physical and speech therapists appointed by the Governor;

6. One representative of the Maine Pharmacy Association appointed by the Governor;

7. One representative of the Maine Hospital Association appointed by the Governor;

8. One representative of the Maine Association of Community Mental Health Centers appointed by the Governor;

9. One representative of the Maine Health Management Coalition appointed by the Governor;

10. The Commissioner of Human Services or the commissioner's designee;

11. The Superintendent of Insurance or the superintendent's designee; and

12. Two members of the Senate appointed by the President of the Senate and 2 members of the House of Representatives appointed by the Speaker of the House of Representatives One member of the Senate and one member of the House shall serve as cochairs of the task force; and be it further

Sec. 3. Appointments. Resolved: That all appointments must be made no later than July 1, 1997. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days of appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the task force; and be it further

Sec. 4. Duties. Resolved: That the task force shall:

1. Gather and examine information from other jurisdictions that have implemented a single claims processing system or have implemented a streamlined claims processing system;

2. Identify barriers and problems that need to be addressed to implement a single claims processing system or to streamline the current claims processing system;

3. Determine resources necessary to implement a single claims processing system or a streamlined system and develop a model for a single claims processing system;

4. Determine the impact on health care providers and health insurance carriers in a single claims processing system or a streamlined system; and

5. Identify the necessary steps for protecting the confidentiality of medical records and proprietary information in a single claims processing system or a streamlined system; and be it further

Sec. 5. Staff assistance. Resolved: That the task force shall request staffing and clerical assistance from the Legislative Council; and be it further

Sec. 6. Reimbursement. Resolved: That the members of the task force are not entitled to any reimbursement or compensation for attendance at meetings of the task force, except that the members of the task force who are Legislators are entitled to receive the legislative per diem and reimbursement for travel expenses for attendance at meetings of the task force. The Executive Director of the Legislative Council shall administer the task force's budget; and be it further

Sec. 7. Report. Resolved: That the task force shall submit its report, together with any necessary implementing legislation, to the Second Regular Session of the 118th Legislature no later than January 1, 1998. If the task force requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 8. Transfer of funds. Resolved: That the Department of Professional and Financial Regulation shall transfer up to $3,860 from the Bureau of Insurance to the Legislature toward the actual expenses incurred by the task force; and be it further

Sec. 9. Allocation. Resolved: That the following funds are allocated from Other Special Revenue funds to carry out the purposes of this resolve.

1997-98

LEGISLATURE

Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-party Payors of Health Care Benefits

Personal Services	$1,760
All Other	2,100
TOTAL	$3,860

Provides funds for the per diem and expenses of legislative members and miscellaneous costs of the Task Force to Study the Feasibility of a Single Claims Processing System for 3rd-party Payors of Health Care Benefits.

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

Appendix B: Members of the Task Force to Study the Feasibility of a Single Claims Processing System for Third-Party Payors of Health Care Benefits

Appointments by the Governor

Kyle E. Andrews
Oxford Hills Family Practice
Norway, Maine 04268
Tel: 743-8031

Representing Maine Medical Association
Maine Osteopathic Association

Joseph R. Mackey, Esq.
The Public Affairs Group
Augusta, Maine 04330
Tel: 623-3787

Representing Health Insurance Association of America

Felix I. Nadeau
Blue Cross /Blue Shield of Maine
2 Gannett Drive
South Portland, Maine 04106
Tel: 822-7000

Representing Blue Cross/Blue Shield of Maine

Juliana L'Heureux
20 Middle Street
Augusta, Maine 04330
Tel: 623-0345

Representing Home Care Alliance of Maine

Gregory D. Jamison
175 Eaton Ridge Road
Holden, Maine 04429
Tel: 989-7543

Representing Maine Pharmacy Association

Suzanne Menard
Southern Maine Medical Center
P.O. Box 626
Biddeford, Maine 04005
Tel: 283-7000

Representing Maine Hospital Association

Leyton E. Sewell
44 Kelly Road
Orono, Maine 04473
Tel: 866-3153

Representing Maine Association of Community Mental Health Centers

Douglas W. Libby
22 Stonebrooke Road
Scarborough, Maine 04074
Tel: 883-4932

Representing Maine Health Management Coalition

Appointments by the President

Sen. Lloyd P. LaFountain, III — Senate Member
322 Alfred Street
Biddeford, Maine 04005
Tel: 282-6131

Sen. I. Joel Abromson — Senate Member
2271 Congress Street
Portland, Maine 04103
Tel: 773-3990

Appointments by the Speaker

Rep. Joseph C. Perry — House Member
P.O. Box 1381
Bangor, Maine 04402
Tel: 945-3934

Rep. Tarren R. Bragdon — House Member
1229 Broadway, Suite 337
Bangor, Maine 04401
Tel: 990-2290

Ex Officio

Glenn Griswold — Superintendent's Designee
Bureau of Insurance — Bureau of Insurance
34 State House Station
Augusta, Maine 04333
Tel: 624-8494

Jim Gorman, Deputy Director — Commissioner's Designee
Bureau of Medical Services — Department of Human Services
11 State House Station
Augusta, Maine 04333-0011
Tel: 287-6888

Staff: Colleen McCarthy Reid and Megan Dennen, Office of Policy and Legal Analysis

Appendix C: Minutes of October 28, 1997 Meeting of the Task Force to Study the Feasibility of a Single Claims Processing System for Third-Party Payors of Health Care Benefits

Task Force members in attendance: Senator Lloyd LaFountain III, Representative Tarren Bragdon, Representative Joseph Perry, Greg Jamison, Felix Nadeau, Kyle Andrews, Steve Michaud, Joe Mackey, Doug Libby, Glen Griswold, Juliana L'Heureux, Leyton Sewell. Absent were: Senator Joel Abromson and Jim Gorman.

Also in attendance: Representative Elaine Fuller; Jay Goldstein, Medical Financial Services; Mike Roy, Maine CHIN; Christine Torraca, Blue Cross Blue Shield of Maine; Jadine O'Brien, Blue Cross, Blue Shield; Al Prysunka, Maine Health Data Organization; Kristina Lunner, Maine Medical Association; Cate Sonnier Pineau, Pineau Policy Associates; Kathryn Reid, PayPower Benefits; Suzanne Menard, Southern Maine Medical Center/UB92 Committee and Audrey Marra, Maine Green Party.

Task Force Convened; Co-chairs Elected

Rep. Elizabeth Mitchell, Chair of the Legislative Council, convened the first meeting of the task force. The first order of business was the election of the co-chairs of the task force. As Resolve 63 required one Senator and one Representative to serve as co-chairs, Sen. LaFountain and Rep. Bragdon were elected after being nominated. Each task force member introduced him or herself and stated the constituency or organization they represented.

The Duties of the Task Force

Resolve 63 requires the task force to do the following:

- Gather and examine information from other jurisdictions that have implemented a single claims processing system or have implemented a streamlined claims processing system
- Identify barriers and problems that need to be addressed to implement a single claims processing system or to streamline the current claims processing system
- Determine the resources necessary to implement a single claims processing system or a streamlined system and develop a model for a single claims processing system
- Determine the impact on health care providers and health insurance carriers in a single claims processing system or a streamlined system
- Identify the necessary steps for protecting the confidentiality of medical records and proprietary information in a single claims processing system or a streamlined system

Origin of the Task Force

Rep. Elaine Fuller, sponsor of Resolve 63, spoke to the task force about her reasons for sponsoring the legislation. She explained that the genesis of the legislation came from two sources: her past experience as director of the Bureau of Medical Services and her daughter's experience as a small non-physician health care provider. She cited from a report on the State of New York's pilot program on electronic claims processing and a claims clearinghouse that greater efficiency and administrative savings can be achieved through the elimination of paper processes, the standardization of claims forms and the participation of all payors under an electronic claims processing model. Rep. Fuller introduced the task force's legislation in hopes that by bringing all of the stakeholders together the prospect of a single claims processing system or a streamlined system of claims processing may be meaningfully discussed and possibly developed.

Overview of Claims Processing

The task force heard brief presentations on claims processing from three perspectives: physician, provider and payor. These presentations were made by Jay Goldstein, Medical Financial Services; Suzanne Menard, Southern Maine Medical Center; and Christine Torraca, Blue Cross Blue Shield of Maine.

Jay Goldstein, Medical Financial Services

Mr. Goldstein works for a company that provides medical billing, claims, purchasing and other professional services to physician practices. He explained that to his knowledge there were two private claims clearinghouses available to physician practices in Maine: Statlink and the National Electronic Insurance Clearinghouse ("NEIC"). However, these two entities are not aggressively marketing their services in Maine and physician practices have to actively seek arrangements with them.

The issues and suggestions mentioned by Mr. Goldstein included: standardization of information required by payors from providers because often payors require different sorts of information in different fields on the claims forms; and streamlining the process for providers when reviewing rejected claims because the current process is cumbersome and often requires extensive follow-up with patients especially on coordination of benefits issues. Another issue mentioned by Mr. Goldstein was the varying UCR (usual, customary rate) rates paid by different carriers for the same service.

Suzanne Menard, Southern Maine Medical Center

Ms. Menard is the director of billing for Southern Maine Medical Center and also chairs the State's Uniform Billing Committee. She began her presentation by outlining the current options for providers with electronic claims:

- direct filing with the payor
- NEIC contract

- NEIC contract
- BCBS clearinghouse (although currently BCBS is not taking new providers into their system due to a change in system and software)
- diskette (although this mode has become outdated)
- remote access (which can be done for Medicare claims)

Ms. Menard also identified some of the barriers to electronic claims processing as: workers' compensation claims, ERISA plans, paper "dump" of electronically submitted claims, late charges, secondary billing and attachments. She also mentioned the need to address the issues and considerations related to the changes in federal law as to electronic claims and confidentiality required under the Health Insurance Portability and Accountability Act's (HIPAA) Administrative Simplification provisions.

Ms. Menard also explained the differences between the two standard claim forms in use. The HCFA 1500 is used by individual and group practitioners of health care services and the UB92 used by institutional providers (hospitals) and other health care facilities.

Her presentation also touched on the state's UB Committee which is affiliated with the National UB committee and charged with the facilitation and implementation of use of the UB92 form in the state. She suggested that the task force utilize the UB92 committee in an advisory capacity, coordinate its efforts with similar projects and build on existing infrastructure.

Christine Torraca, Blue Cross Blue Shield of Maine

The final presentation on claims processing was made by Christine Torraca of Blue Cross Blue Shield. She started by stressing that in the current health insurance marketplace there are four areas or market differentiators that can be used by payors to compete in this market: benefit design, networks, contracts and electronic capabilities. All of these differentiators impact the claims transaction. Ms. Torraca described the claims transaction as an event that occurs one time or many times within the context of the payor's relationship with the member, the provider and the group decision maker. She also outlined the claims transaction timeline as pre-transaction activities and post-transaction activities. Pre-transaction activities include the selection of a BCBS product; member enrollment; choice of primary care physician; assignment of benefits; determination of premiums and payment of premiums. Once the claims transaction is triggered by the member receiving services, the claim is processed. After the provider bills for the service and BCBS receives the claims, the centerpiece of the provider's end of the claims process is the adjudication of the claim. The steps of adjudication are a determination of member eligibility, of provider eligibility of service level edits and of payments and liabilities. Once the claim is adjudicated, it can be paid. The post-transaction activities are focused on the data records created by the claim and the reports that are generated from that information.

Maine Projects in Claims Processing and Data Collection

The last presentations of the afternoon were made by Mike Roy from the Maine CHIN and Al Prysunka from the Maine Health Data Organization.

Maine CHIN

Mike Roy explained the establishment and ongoing efforts of the Maine Community Health Information Network. The CHIN was founded in 1995 for the purpose of developing an efficient and compatible health information network for the support of providers and payers of health care in Maine. The CHIN was founded by the following organizations: Maine Medical Association, Maine Osteopathic Association, Maine Department of Human Services, Blue Cross and Blue Shield of Maine, Healthsource Maine, Maine Medical Assessment Foundation and Maine Health Management Coalition.

Mr. Roy outlined the phases of the CHIN project and the hope that phase I of the project would be rolled out in the 2nd quarter of 1998. The CHIN has been designed as an information superhighway, a computer-based intranet system providing a single point of entry for both providers and physicians that links them with each other and with payors. More information on the CHIN project will be provided at our next meeting.

Maine Health Data Organization

Al Prysunka outlined the data collection functions of the Maine Health Data Organization. The Maine Health Data Organization is an independent executive agency charged with the collection, storage, processing and analysis of clinical, financial and restructuring data from health care providers. The MHDO was formed to carry on the data collection functions of the Maine Health Care Finance Commission which was abolished on July 1, 1996. One of the sources of clinical data provided to the MHDO from hospitals and other health care facilities is the UB92 claim form. Mr. Prysunka explained that the current process for submitting data was cumbersome and the MHDO board was exploring ways to simplify the submission of data by providers. One approach being discussed is to require hospitals to use only the UB92 for their data submission and to other providers to use the HCFA 1500 form. This would eliminate the use of separate forms previously required by the Maine Health Care Finance Commission and inherited by the Maine Health Data Organization.

Next Meeting

At the next meeting, the task force will be provided with more information on claims processing, including a glossary of terms and sample UB92 and HCFA 1500 claim forms; on electronic claims processing efforts in other states, including New York; on the requirements of the federal HIPAA law; and on the Maine CHIN.

The next meeting of the Task Force will be held
Wednesday, Nov. 12th
in Room 221 of the State House
from 10:00 a.m. to 4:00 p.m.

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Appendix D: Minutes of November 12, 1997 Meeting of the Task Force to Study the Feasibility of a Single Claims Processing System for Third-Party Payors of Health Care Benefits

Task Force members in attendance: Representative Tarren Bragdon (Chair), Senator Joel Abromson, Felix Nadeau, Kyle Andrews, Suzanne Menard, Joe Mackey, Glen Griswold, Juliana L'Heureux, Leyton Sewell, Greg Jamison. Absent were: Senator Lloyd LaFountain III, Representative Joseph Perry, Doug Libby, and Jim Gorman.

Also in attendance: Representative Elaine Fuller; Mike Roy, Maine CHIN; Alice Chapin, Maine Health Data Organization, Liz Pickett, Blue Cross/Blue Shield (Capella), Kristina Lunner, Maine Medical Association

Staff Presentations

Glossary
Task Force members had requested a glossary of terms at the last meeting. Megan compiled a list of claims processing and electronic data interchange words into a basic glossary to be used as a reference for members.

Sample Forms (UB-92 and HCFA-1500)
Sample forms for the UB-92 used by facilities and HCFA-1500 used by physicians were provided to the committee. Suzanne Menard reviewed the areas on the forms that cause confusion. Advantages and disadvantages of both forms were discussed.

Chart of claims processing
Colleen reviewed the different components of claims processing. The entire process can be divided into the front end and back end. The front end includes physician offices, hospitals and other providers gathering information and filling out claims forms. The back end begins when the payer receives the claim and begins the adjudication process. This portion of the system can also include requesting additional information from the provider or the insured.

Models from other states
Megan presented information on progress in other states to simplify administrative processing of health care claims. The states covered include: New York, New Jersey, Maryland and Utah. New York was involved in a pilot electronic claims processing program from 1990 to 1994 and now mandates that all claims be submitted electronically. New Jersey completed a survey in 1994 determining the usage, cost and benefits of electronic claims submission compared to paper claims. Maryland mandated filing of claims electronically in 1993, but then repealed the start date and implemented a voluntary certification program for clearinghouses. Utah Health Information Network (UHIN) has been functioning since 1993 and allows providers and payers to submit claims via a single network.

Health Insurance Portability and Accountability Act (HIPAA)
Colleen explained the requirements of HIPAA as they relate to electronic transmission of claims and privacy and confidentiality. Standards should be announced soon by the Department of Human Services for the transmission of claims. They will be adopted in February, 1998 and compliance with rules should occur by February 2000 (small insurance plans by February 2001). A report concerning privacy of individually identifiable health care information was submitted to Congress in September 1997. Congress has until August 1999 to enact legislation, otherwise the Department of Human Services must adopt rules.

Maine Health Information Network

Alice Chapin, Maine Health Data Organization
Alice explained that after moving around and considering the formation of a whole independent agency, the CHIN currently is a permanent department under the Maine Health Information Center. Implementation of the CHIN network is scheduled to begin in pilot sites in early 1998 and will add members incrementally as the bugs get worked out. MECHIN has contracted with the Capella division of Blue Cross and Blue Shield to provide the administrative portion of the CHIN.

Mike Roy, Maine Community Health Information Network (CHIN)
Mike reviewed the goals of the CHIN and named some of the other CHINs that are currently in place and successful (Wisconsin, California, Dayton and Utah). The CHIN went through a long process of planning and consensus building to get the project to this stage. The CHIN realized the need to evaluate the cost savings for physicians, hospitals and payers. The Health Division of Ernst and Young determined that within three years each participant will see a cost savings. Mike reminded the task force that the CHIN is a telecommunications network and NOT a data repository.

Liz Pickett Capella group, Blue Cross/Blue Shield
Ms. Pickett explained to the task force the way clearinghouses in general and the ME CHIN specifically function. She listed the key components of a clearinghouse and explained how the ME CHIN satisfies these functions to a superior degree. (See attached handouts)

Task Force Discussion

The Task Force members began to discuss their impressions of the information presented, the problems faced and the potential solutions. The group reviewed the task force duties as set out in legislation. Some of the issues raised during the discussion include:

- focusing on simplifying the “front end”
- mandates may have a negative impact on small, rural providers (and payers)
- what can be done to encourage more use of existing technologies?
- what will be the impact of the Maine CHIN?
- what will be the impact of the HIPPA regulations?
- progress is being made without government assistance

After examining the duties required in the legislation, the task force decided it would like to compile some draft findings and recommendations to review at the next meeting. Megan and Colleen hope to mail out a draft before the next meeting on November 25th.

The next meeting of the Task Force will be held
Tuesday, Nov. 25th
in Room 221 of the State House
from 1:00 p.m. to 4:00 p.m.

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