MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1365

2001 HOUSE HUMAN SERVICES

HB 1365

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1365

House Human Services Committee

☐ Conference Committee

Hearing Date January 30, 2001

Tape Number	Side A	Side B	Meter #
Tape 3	X		1125 to end
Tape 3		X	0 to 360

Committee Clerk Signature Connie Easton

Minutes:

Chairman Price, Vice Chairman Devlin, Rep. Dosch, Rep. Galvin, Rep. Klein, Rep. Pollert, Rep. Porter, Rep. Tieman, Rep. Weiler, Rep. Weisz, Rep. Cleary, Rep. Metcalf, Rep. Niemeier, Rep. Sandvig

Chairman Price: Open hearing on HB 1365.

Rep. Nottestad: Presented Bill. Changes in this bill are the same problems other states are having. I will turn this over to the experts in this field.

Galen Jordre: Executive Vice President, N.D. Pharmaceutical Association. (See written testimony.) The Association strongly supports HB 1365 in an attempt to pro ide for uniform prescription cards. HB 1365 is based on model legislation developed by a coalition of national pharmacy organizations and allows the greatest degree of flexibility for insurers and other entities to meet its requirements. I ask your support and a yes vote on HB 1365.

Rep. Winrich: Cosponsored Bill. I want to express my support of this bill as a cosponsor. It is a real problem that pharmacists face and I hope you will give consideration to this bill.

Rep. Weisz: How ill HIPPA affect this bill?

Galen Jordre: We feel that HIPPA will incorporate into the regulations.

Rep. Weisz: You don't anticipate having to change this format?

Galen Jordre: I would not anticipate any significant change. This should ease the claim process.

Rep. Sandvig: Could you explain what the RX's numbers are?

Galen Jordre: The Processor Control Number, if we have a company that is a national claims processor known as PCS, they probably program over a 1,000 different types of companies, so that's what they use the RXBIN for. The RXBIN will get the claims to PCS. Then you have a company who may have different plans in different states. Then the Process Control Number would be used to separate those particular elements. Same as RX Group would be another divider if you had multiple types of plans that designate your RX group. They all may be needed to transmit the prescription.

Chairman Price: This isn't going to require any new cards until a change in coverage or a change in enrollment?

Galen Jordre: No. It does not require change unless they change their claims processor.

Tony Welder: Part Owner of Dakota Pharmacy. This bill is a common sense bill that is a win, win solution for the processor, for the pharmacist, and most of all for the patient. This is such a common sense, low cost thing to do, that I urge your support of this bill.

Howard Anderson: Executive Director, Board of Pharmacy. (See support of HB 1365 in written testimony.) We would like you to support this bill, not because it is a regulatory issue, but

because we see pharmacists time being taken away from the patient's care unnecessarily. Thank you for your consideration.

Rep. Cleary: Do Florida and Arizona have these cards yet?

Howard Anderson: I don't know that.

Rep. Weiler: If I'm one of those people that have to wait another nine or ten years before I get my new card, does that mean that over the next nine or ten years I have to go through all of this trouble before I get a new card?

Howard Anderson: I would encourage you to stay with the same pharmacy that already knows how to process your card.

Rep. Porter: How will requirements work with magnetic strip technology?

Howard Anderson: If insurance cards were like credit cards it would be great, but if credit cards were like insurance cards are now we could never buy anything.

Rod St. Aubyn: Government Relations, Blue Cross/Blue Shield. (See support of bill in written testimony.) Two parts of this bill make it more favorable for us, you don't have to issue cards right away and this bill allows cards to be combined (medical and prescription.)

Rep. Sandvig: Is there any attempt to get rid of Social Security numbers on the card for privacy issues?

Rod St. Aubyn: You can request that.

Dan Ulmer: BC/BS. We are looking at that issue right now. It is a security issue.

David DeBuhr: Bismarck Pharmacist. I am in favor of HB 1365. Frankly, it is very irritating not to spend quality time with our patients because we're spending too much time on the telephone.

Brenda Blazer: Health Insurance Association of America. (See written testimony.) There are significant operational costs associated with a mandated benefits card with no increase in benefits. We respectively ask for a DO NOT PASS.

Rep. Dosch: Putting policy numbers and group numbers on cards - what is the problem with that? Why is that such a big obstacle??

Brenda Blazer: It isn't a problem, and it won't be a problem. Our objection is state by state enactment of prescription drug card legislation results in anything but "uniform" drug cards.

Chairman Price: Close hearing on HB 1365.

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1365 A

House Human Services Committee

☐ Conference Committee

Hearing Date January 31, 2001

Tape Number	Side A	Side B	Meter #
Tape 3	X		1225 to 2400
Committee Clerk Signature	Carmen Easton		

Minutes:

COMMITTEE WORK:

CHAIRMAN PRICE: 1365. Mr. Jordre, since you're in the room may I ask you a couple of questions. There was discussion about HIAA and the fact that there is not a uniform standard yet. Should we take a look at that in delaying this for HIPAA?

GALEN JORDRE: Executive Vice President, N.D. Pharmaceutical Association. When they talked about the lack of standards, I think they were saying that in some states where legislation has passed then language about this particular area has been put in. Some of those cases they added additional data elements that we're not talking about. The NCPDP standards since they have been developed have been barely ..... In other words they have three versions of this that have come out.

CHAIRMAN PRICE: Of the seven states that have passed it, are their cards going to look like the samples that you gave us.

GALEN JORDRE: I know for sure that at least three or four of them are going to it. A couple of the states have passed, such as Texas, passed their insurance cards regulation out side of this current effort that we're involved in. It was a uniform legislation that was part of a health care reform package - a privacy package they instituted in Texas. In that case they have additional requirements all of the states that are working off of the same model language are adopting these standards. I do have a personal interest in this. My wife is a pharmacist and a lot of the time she works longer than I do. So it is my job to cook dinner, and I can tell you there have been a lot of times that I've been home fuming because I'm wondering where she is. She comes home and says we were all ready to leave, and somebody came in with a new card prescription and we couldn't get it to work.

REP. POLLERT: I know that BCBS testified in favor. This shouldn't be a problem for other companies to accept this standard card?

GALEN JORDRE: In time it may cause these other companies a problem.

CHAIRMAN PRICE: It doesn't say anything - if I'm a company licensed to do business in the State of North Dakota this applies to me. If I insure someone who technically lives in Minnesota and bought insurance in Minnesota and they happen to be working in Fargo, they want to buy their drugs at a Fargo pharmacy - that doesn't put any requirements on them?

GALEN JORDRE: The Insurance Commissioner would have the ability to regulate it. It is my understanding that that regulation comes through their power to review the policies for policies that are sold and delivered in North Dakota. If it was used for someone from out side the state than it would not. Part of that is the reason why the Minnesota Pharmaceutical Association is doing the same thing as we are.

REP. SANDVIG: I have a question on the insurance number that is developed as part of HIPPA.

How are you going to know what number to give them when HIPPA hasn't even come out with the numbers yet?

GALEN JORDRE: HIPPA is a very big mystery at the present time, but at some point in time there will be developed a universal provider numbers for those insurance companies. Those will be the numbers that will be used in that case. It will be a national number.

REP. SANDVIG: How are you going to make the cards and have that number on there if it isn't already developed by HIPPA, and if they are made out will you have to make new cards?

GALEN JORDRE: The insurance companies at the time when HIPPA goes into place - if a number is required, they will be placing them on. If they are using a card for medical information the same as with a prescription card, they would be using that HIPPA number.

REP. CLEARY: So you're saying that when that happens you will have to issue a new card.

GALEN JORDRE: They would not have to issue a new card, because they would have the information in place already that we would need to transmit the prescription. If they would change over their system, then they would have to replace it. But as long as they had their existing methods so we knew the data, then they wouldn't have to replace it.

CHAIRMAN PRICE: Okay committee, we have a bill in front of us. What would you like to do?

REP. NIEMEIER: DO PASS.

REP. KLEIN: Second.

CHAIRMAN PRICE: Further discussion. Seeing none the clerk will take the roll on a **DO PASS.**

14 YES 0 NO 0 ABSENT REP. TIEMAN

FISCAL NOTE

Requested by Legislative Council
01/22/2001

Bill/Resolution No.: HB 1365

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill is not anticipated to have any fiscal effect on PERS.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Sparb Collins	**Agency:**	Public Employees Retirement System
Phone Number:	328-3901	**Date Prepared:**	01/25/2001

Date: 1-31-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1365

House Human Services Committee

☐ Subcommittee

or

☐ Conference Committee

Legislative Council Amendment Number

Action Taken DO PASS

Motion Made By Rep. Niemeier Seconded By Rep. Klein

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price, Chairman	✓		Rep. Audrey Cleary	✓	
Rep. William Devlin, V, Chairman	✓		Rep. Ralph Metcalf	✓	
Rep. Mark Dosch	✓		Rep. Carol Niemeier	✓	
Rep. Pat Galvin	✓		Rep. Sally Sandvig	✓	
Rep. Frank Klein	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Wayne Tieman	✓				
Rep. Dave Weiler	✓				
Rep. Robin Weisz	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Rep. Tieman

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 1, 2001 10:39 a.m.

Module No: HR-18-2086
Carrier: Tieman
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1365: Human Services Committee (Rep. Price, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1365 was placed on the Eleventh order on the calendar.

2001 SENATE HUMAN SERVICES

HB 1365

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1365

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 20, 2001

Tape Number	Side A	Side B	Meter #
2	X		15.3
February 21, 2001 1	X		21.2
Committee Clerk Signature	Carol Kolodziczuk		

Minutes:

The hearing was opened on HB 1365.

REPRESENTATIVE NOTTESTAD, sponsor, supports bill. Pharmacist daughter asked to have work on prescription cards.

GALEN JORDRE, JR., R.Ph. Executive Vice Pres., explained and supports bill with written testimony.

ROD ST. AUBYN, BCBS, supports bill. They will not have trouble with being able to conform to the card description.

HOWARD ANDERSON, JR., Executive Director of ND State Board of Pharmacy, supports bill with written testimony.

Opposition:

BRENDA BLAZER, Health Insurance Association of America, opposes bill. It is unnecessary to put this into statute. The Feds will have a law in a short time.. (Written testimony)

The hearing was closed on HB 1365.

February 21, 2001, Tape 1, Side A, Meter 21.1.

GALEN JORDRE, R.PH, Assoc., informed us of further investigation in the development of the Pharmacy ID card. SENATOR MATHERN: Is this going to be compatible with NCPDP. MR. JORDRE: Yes. SENATOR POLOVITZ: What is HIPPA? MR. JORDRE: Health Insurance Portability and Accountability Act. Formed to facilitate people to move their insurance more freely from one job to another job. SENATOR MATHERN moved a DO PASS. SENATOR POLOVITZ seconded the motion. Roll call vote carried 6-0. SENATOR LEE will carry the bill.

Date: 2/21/01

Roll Call Vote #: 1 ~~365~~

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1365

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Sen Mathern Seconded By Sen Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 21, 2001 2:09 p.m.

Module No: SR-32-4232
Carrier: Lee
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1365: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1365 was placed on the Fourteenth order on the calendar.

2001 TESTIMONY

HB 1365

North Dakota Pharmaceutical Association

1906 E Broadway Ave. ♦ Bismarck ND ♦ 58501-4700
Telephone 701-258-4968
FAX 701-258-9312
E-mail ndpha@nodakpharmacy.com

Testimony on HB 1365
House Human Services Committee
January 30, 2001
Galen Jordre, R.Ph. – Executive Vice President

The North Dakota Pharmaceutical Association (NDPhA) represents the 670 pharmacists licensed to practice pharmacy in this state. These pharmacists provide services to patients through 175 community retail pharmacies and 56 institutional pharmacies located in 73 different communities of our state.

The North Dakota Pharmaceutical Association strongly supports HB 1365, an attempt to provide for uniform prescription information cards. Our members have identified the lack of a uniform prescription information card as one of their greatest irritants. All patients who participate in a prescription benefit program are issued some type of a medical identification card or prescription benefit card. In the United States today, upwards of 70% of prescriptions are paid for by one of many insurance programs, each with its own unique prescription information card. Claims are handled by electronic transmission and pharmacists rely on accurate information on the insurance information cards to access the data needed to transmit the claims. Dealing with the administrative burdens created by inconsistent and confusing prescription information cards creates unnecessary barriers to pharmacists providing care to their patients.

Surveys of pharmacists by the Pharmaceutical Society of the State of New York, The American Pharmaceutical Association and a study funded by the National Association of Chain Drug Stores indicate that lack of a single card format is a primary impediment to productivity of pharmacists. The NACDS survey indicates that up to 20% of pharmacy personnel time is spent dealing with insurance related issues. The problem will only become more acute over time as insurance programs cover more consumers and workloads increase. While many cards currently in use in North Dakota meet the standards, uniform requirements are needed because large numbers of cards do not. Cards come from all over the nation and by implementing standards in North Dakota greater uniformity can be achieved. This same type legislative effort is being launched in over 20 states this year and seven states have adopted uniform measures.

HB 1365 is based on model legislation developed by a coalition of national pharmacy organizations and has been laid out to allow the greatest degree of flexibility for insurers and other entities to meet its requirements.

Section 1 outlines the requirements for the information cards.

Sub-section 1. indicates the entities that are covered by the Act. The language addresses the types of entities that provide the coverage such as insurance companies who often are the issuers of information cards. It also includes additional parties such as pharmacy benefits managers and third-party administrators who may issue cards on behalf of the insurance companies. In the case of large

national pharmacy benefits managers, they issue cards on behalf of 100's of plans and companies. Without a uniform information card, pharmacies have no way of always verifying who is responsible for issuing the card and providing information about the plan.

Sub-section 2. indicates the type of information that must be included on the information card. The important part of this sub-section is that it implements the standards developed by the National Council for Prescription Drug Programs (NCPDP).

The NCPDP is the standards setting organization for pharmacy claims transmission and is recognized by insurers, pharmacy benefits managers, and pharmacy groups. The NCPDP has identified information that must be included on information cards in order for claims to be successfully transmitted and has developed an implementation guide show how the essential elements must be positioned on the card to insure uniformity. In the process of developing the standard elements the NCPDP has worked with the National Committee for Information Technology Standards (NCITS), a group that is developing a uniform health care identification card standard and with the American National Standards Institute (ANSI). ANSI has approved the health care ID card standard and the NCPDP standard incorporates those elements.

The NCITS has three required data elements (Issuer, ID, and Name) and the NCPDP implementation guide incorporates one additional required field, the BIN. There are conditional fields such as the Group Number and Processor Control Number. When these fields are required for proper claims adjudication, they are also required data elements. A sample card with required elements is shown below:

FRONT

Desired Name/Logos

RxBIN (Required)
RxPCN(Conditional)
RxGrp (Conditional)
Issuer (Number developed as a part of HIPAA)
ID **12345678901** (Required)
Name **JOHN Q PUBLIC** (Required)

BACK

Pharmacy Help Desk: (800) 555-1234
Customer Service: (800) 555-9876
Submit Claims to:
Any Pharmacy Benefits Manager
123 ABC Street
Anytown, MO 00000-0000

This Act does provide some discretion to the Insurance Commissioner. If insurers or plans would require data elements that are not specified as required or optional under the NCPDP guide, the commissioner would approve the format. In addition if for some reason the NCPDP standards would be replaced by some other national standard, the Insurance Commissioner would be able to accept that format.

Sub-section 3. describes when new information cards would be issued. There is no requirement that an insurer or plan replace current cards in place. The Act allows replacement of cards when a plan normally reissues cards or when there are plan changes that require changes in the data the pharmacies must use to transmit claims. The Act even allows the insurers or plans to use stickers to update the cards when there are changes made, without having to issue new cards. There should be very minimal expense because new cards are not required. The only costs would result from reformatting the way already variable information is printed on the cards.

Sub-section 4. allows the information card to be used for any health insurance coverage. The NCPDP Implementation Guide has several formats that can be used to effectively combine prescription information and medical identification information on the same card. There is no requirement for separate prescription information cards and there should be no additional costs because new cards are required.

Section 2. This section requires the PERS Board to provide uniform information cards. PERS has prepared a fiscal note indicating that the Act will have no fiscal impact on the Board.

Adoption of this Act will bring relief to North Dakota pharmacists and patients. The industry may ask why we are asking for these standards in law rather than working on a voluntary basis. The NCPDP standard was supposed to be voluntary. However the standard was developed four years ago and voluntary implementation hasn't happened. Voluntary compliance ... as with the Pharmacy Benefit Manager Express Scripts... is preferred but the problem is so profound for pharmacy that the issue must be pursued since waiting for voluntary compliance has not worked. National pharmacy groups have worked with insurers for almost two years to try to get agreement and no response has been received. Even this last year, the National Association of Chain Drug Stores met with the Health Insurance Association of America two times to forge a voluntary approach but has not had any success.

The current system that pharmacists and patients must currently deal with is not working and we continually hear about more problems. I have included a card that David Olig, the owner of Southpointe Pharmacy in Fargo, had to work with last week. Dave was going to appear before you today but could not because of bad weather. If you would look at the Health Partners card and I will point out the problems he faced.

This bill is just not for the benefit of pharmacies. It does help consumers and even insurers by providing the following benefits:

1. Dealing with insurance issues is the single biggest problem identified by pharmacist as increasing wait times for patients.
2. This interferes with a pharmacist's ability to meaningfully interact with consumers and help them avoid problems such as med. errors identified by the IOM study.
3. Some pharmacies are actually having portable phones installed and making patients deal directly with their insurance company.
4. This decreases rejected claims and the costs associated with them.
5. This helps pharmacy, consumers and INSURERS by decreasing calls to the help desk and decreasing consumer's irritation.

You can act now by passing this Act and joining other states to create a uniform standard that will create compliance by insurance companies and benefits managers. It will help North Dakota patients when they are in other states and have their prescriptions filled by having standard information that those pharmacies understand and use for speedy prescription adjudication. The provision for benefits managers and third party administrators will help when those entities outside the state issue information cards to patients residing in North Dakota. Passage will allow pharmacists to spend more time with patient care and less with working on insurance snarls that delay provision of medications to waiting patients. North Dakota is one piece of a national puzzle and can play a vital role if this legislation is passed.

We ask your support and yes vote on HB 1365.
Thank You

HealthPartners.

ID	[redacted]	Account [redacted]	01/01
Name	[redacted]		
Care Type	Primary Clinic Choice with Copay Options HealthPartners		
Office	$20.00		
Rx BIN 610468 HP	See SPD		
ER	$75.00		
Urgent	$20.00		
Deductible	$0.00		
	PCP Code	PCP or Network	
Medical	883	MERITCARE CLINIC SOUTHPOINTE	

1. The first time I tried to transmit the prescription with the ID number, Account number, and Rx Bin number. It did not work. I saw my computer system has 29 different plans under the BIN number 610468.

2. This card is processed through Pharmacare – No where on the card does it say that. The help desk number is for HealthPartners.

3. The group number is 6035 1000 – It is not listed on the card. It is not the account number [redacted] as listed. I called HealthPartners help line and they transferred me to Pharmacare to get the right group number.

4. A second call was needed when the claim would not go through. I was told you need to put a 0 in front of the patient's ID number to get it to work.

5. I tried to transmit this 9 different ways before I got it to go through.

6. Pharamacare told me they didn't have this patient listed in their records. It was only after trying every possible combination that I got it to go through. Total time on the prescription was over 25 minutes. Dispensing fee was less than $3.00.

7. The patient's mother was very patient and understanding which is wonderful or these turn into a nightmare.

David Olig, R.Ph.
Southpointe Pharmacy
701-234-9912

BlueCross BlueShield † CATHOLIC HEALTH INITIATIVES

[redacted]

Identification No. [redacted]

Group No. C20000 01-01-01 Copays: Office Visit $10 Emergency $50

BE Plan Code 621 BC Plan Code 121

PPO Option A CH22022

I was on the Phone for 15 minutes To get This contract To process. The Group # is really CH 22022 NOT C 20000

And The plan Needed a Person code No Info on card!

Name of PBM or Insurance: PAID

☒ Incomplete or missing group number.... discuss 3 letters on ID # ONE NOT ALLOWED FOR PROPER ADJUDICATION

☐ Have to add digits or character

☐ Cannot identify where to bill cla

☐ Help desk information for patie

☐ Have to obtain data not on carc

State Health Plan
State of South Carolina
State Agencies, Public School Districts and Other Participating Groups

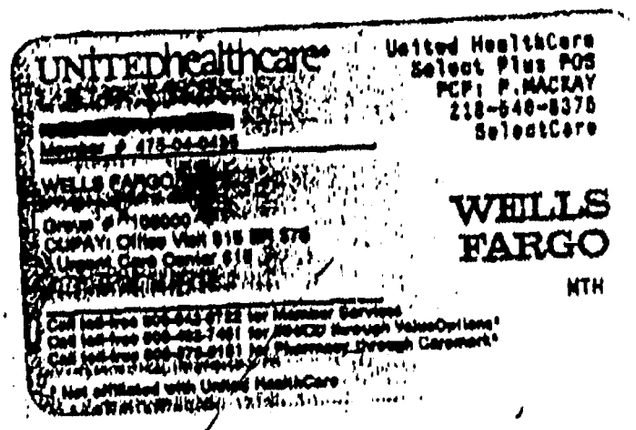
2CSS [redacted]

group # STATESC

This State Health Plan identification card is the property of the State of South Carolina. Claims administration is provided by Blue Cross and Blue Shield of South Carolina.

☐ Birth date or relationship (if needed) is not accurate.... discuss

Pharmacy Name: Key Care Pharmacy



Use
24-180
Group = WELLS

Gary -
On this card we had to use group # WELLS but the card said Group # 108000 - OK what's wrong ?? !!

ID-8297734 P07

Choice Plus

ID	818579978	TARGET Account 04628 03/01
Name	[redacted]	
Care Type	CHOICE PLUS Choice Plus	Bin # 610041
Office	$10.00	
ER	$75.00	Group 505
Urgent	$10.00	
Deductible	$0.00	
	PCP Code	PCP s/ Network
Medical	867	COMMUNITY [illegible]

On this Card
No Bin#
No Group#

Board of Pharmacy
STATE OF NORTH DAKOTA
EDWARD T. SCHAFER, Governor

OFFICE OF THE EXECUTIVE DIRECTOR
P.O. Box 1354
Bismarck, North Dakota 58502-1354
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Fargo, Senior Member
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Horace
GARY W. DEWHIRST, R.Ph.
Hettinger
WILLIAM J. GROSZ, Sc.D., R.Ph.
Wahpeton, Treasurer
HOWARD C. ANDERSON, Jr., R.Ph.
Turtle Lake, Executive Director

HOUSE BILL NO. 1365
TUESDAY JANUARY 30TH- 3:30 PM- FORT UNION ROOM
HOUSE HUMAN SERVICES COMMITTEE

Committee Chair Price, members of the House Human Services Committee, for the record I am Howard C. Anderson, Jr., R.Ph., Executive Director of the North Dakota State Board of Pharmacy.

We would like you to support this bill, not because it is a regulatory issue, but, because we see pharmacist's time being taken away from patient care unnecessarily when they are dealing with third party prescription coverage issues.

Again and again across the country pharmacists list frustration with third party prescription payment programs as their primary irritant as well as taking an inordinate amount of their time.

Streamlining this process would allow pharmacists less distractions in the work place, less propensity for errors in prescription dispensing and more time to spend taking care of patients.

Thank you for your consideration.

Testimony for HB 1365
House Human Services Committee
January 30, 2001

Madam Chair and committee members, for the record I am representing Blue Cross Blue Shield of North Dakota. BCBSND appears in support of HB 1365. I recently had the opportunity to visit with a local pharmacist concerning this proposed bill. He illustrated the problems that pharmacists have with the numerous prescription drug cards. He emphasized that they do not have problems with BCBSND's card. However, that may not be the case for out of state pharmacists.

We feel that the bill provides enough options to prevent any unnecessary costs. We would also oppose a separate card for prescriptions. This bill still allows one card to be used.

Madam Chair and Committee Members, for the reasons stated we would support this bill. Thank you.

Dan Ulmer and Rod St. Aubyn
Government Relations
Blue Cross Blue Shield of North Dakota

Brenda L. Blazer
Health Care Association of America

TESTIMONY IN OPPOSITION TO HB 1365
House Human Services Committee
January 30, 2001

The Health Insurance Association of America (HIAA) is an insurance trade association representing insurance companies that write accident and health insurance on a nationwide basis. The HIAA and its members strongly oppose HB 1365 mandating use of a "uniform" prescription drug card.

The National Council of Prescription Drug Programs was organized by health insurers, health plans, pharmacists and pharmacies to develop voluntary standards for submission of pharmacy claims. The National Association of Chain Drug Stores is now supporting state-by-state enactment of laws that would make the voluntary standards mandatory. Unfortunately, state-by-state enactment of prescription drug card legislation results in anything but "uniform" prescription drug cards.

Most insurance companies provide a single health benefits care for participants to use for accessing all types of medical care. HB 1365 requires insurance companies to comply with the most recent pharmacy information card or technology implementation guide produced by the national council of prescription drug programs or a format acceptable to the insurance commissioner. To comply, the insurance companies would not only have to include certain information on the card, but would also have to list the information in a certain order.

The NDPDP voluntary standards include mandatory and optional information fields. Of the states who have enacted prescription drug card legislation, some have mandated only the required fields. Also, HB 1365 leaves open the option for the insurance commissioner to develop a different format. Insurance companies, who do business in several states, are faced with different laws or regulation in each state which passes prescription drug legislation rather than a "uniform" law. The goal of the NCPDP - to encourage the use of a uniform national format, will not be accomplished as variations in requirements have resulted, and will continue to result, as different states enact different variations of this type of mandate.

If enacted, this bill would result in significant operational and administrative costs associated with a conversion of health benefit coverage cards to a format specified by only one of the many types of health care providers utilizing the health benefits card. For health policies that cover dental or vision, those dentists and optometrists may also want to mandate changes in the health benefits card tailored to their needs.

Further, there have been ongoing changes to the NCPDP implementation guide. The guide was changed four times in the first 18 months. Health insurers and health plans would be required to conform to the latest implementation guide on an ongoing basis. HB 1365 does not require the issuance of a separate prescription benefit card as long as all the required information in on the card in the approved format. Clearly, prescription drug information trumps all other health benefit information. If the information required for all health benefits does not fit on the card, the issuance of a separate prescription drug card is necessary.

All health benefit mandates increase costs. The statistics indicate that for each one percent increase in the cost of health care coverage 200,000 Americans lose their health insurance. There are significant operational and administrative costs associated with a mandated benefits card with no increase in benefits.

HIAA, on behalf of all its members who do business in multiple states, respectfully request the committee give HB 1365 a "do not pass" recommendation.

Board of Pharmacy
STATE OF NORTH DAKOTA
EDWARD T. SCHAFER, Governor

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HOWARD C. ANDERSON, Jr., R.Ph.
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HOUSE BILL NO. 1365
TUESDAY FEBRUARY 20TH- 10:45 AM- RED RIVER ROOM
SENATE HUMAN SERVICES COMMITTEE

Committee Chairman Lee, members of the Senate Human Services Committee, for the record I am Howard C. Anderson, Jr., R.Ph., Executive Director of the North Dakota State Board of Pharmacy.

We would like you to support this bill, not because it is a regulatory issue, but, because we see pharmacist's time being taken away from patient care unnecessarily when they are dealing with third party prescription coverage issues.

Again and again across the country pharmacists list frustration with third party prescription payment programs as their primary irritant as well as taking an inordinate amount of their time.

Streamlining this process would allow pharmacists less distractions in the work place, less propensity for errors in prescription dispensing and more time to spend taking care of patients.

Thank you for your consideration.

Howard C. Anderson, Jr, R.Ph.
ND State Board of Pharmacy

Testimony for HB 1365
Senate Human Services Committee
February 20, 2001

Madam Chair and committee members, for the record I am representing Blue Cross Blue Shield of North Dakota. BCBSND appears in support of HB 1365. I recently had the opportunity to visit with a local pharmacist concerning this proposed bill. He illustrated the problems that pharmacists have with the numerous prescription drug cards. He emphasized that they do not have problems with BCBSND's card. However, that may not be the case for out of state pharmacists.

We feel that the bill provides enough options to prevent any unnecessary costs. We would also oppose a separate card for prescriptions. This bill still allows one card to be used.

Madam Chair and Committee Members, for the reasons stated we would support this bill. Thank you.

Dan Ulmer and Rod St. Aubyn
Government Relations
Blue Cross Blue Shield of North Dakota

North Dakota Pharmaceutical Association

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Testimony on HB 1365
Senate Human Services Committee
February 20, 2001
Galen Jordre, R.Ph. – Executive Vice President

The North Dakota Pharmaceutical Association strongly supports HB 1365, an attempt to provide for uniform prescription information cards. Our members have identified the lack of a uniform prescription information card as one of their greatest irritants. All patients who participate in a prescription benefit program are issued some type of a medical identification card or prescription benefit card. In the United States today, upwards of 70% of prescriptions are paid for by one of many insurance programs, each with its own unique prescription information card. Claims are handled by electronic transmission and pharmacists rely on accurate information on the insurance information cards to access the data needed to transmit the claims. Dealing with the administrative burdens created by inconsistent and confusing prescription information cards creates unnecessary barriers to pharmacists providing care to their patients.

Surveys of pharmacists by the Pharmaceutical Society of the State of New York, The American Pharmaceutical Association and a study funded by the National Association of Chain Drug Stores indicate that lack of a single card format is a primary impediment to productivity of pharmacists. The NACDS survey indicates that up to 20% of pharmacy personnel time is spent dealing with insurance related issues. The problem will only become more acute over time as insurance programs cover more consumers and workloads increase. While many cards currently in use in North Dakota meet the standards, uniform requirements are needed because large numbers of cards do not. Cards come from all over the nation and by implementing standards in North Dakota greater uniformity can be achieved. This same type legislative effort is being launched in over 20 states this year and seven states have adopted uniform measures.

HB 1365 is based on model legislation developed by a coalition of national pharmacy organizations and has been laid out to allow the greatest degree of flexibility for insurers and other entities to meet its requirements.

Section 1 outlines the requirements for the information cards.

Sub-section 1. Indicates the entities that are covered by the Act. The language addresses the types of entities that provide the coverage such as insurance companies who often are the issuers of information cards. It also includes additional parties such as pharmacy benefits managers and third-party administrators who may issue cards on behalf of the insurance companies. In the case of large national pharmacy benefits managers, they issue cards on behalf of 100's of plans and companies. Without a uniform information card, pharmacies have no way of always verifying who is responsible for issuing the card and providing information about the plan.

Sub-section 2. indicates the type of information that must be included on the information card. The important part of this sub-section is that it implements the standards developed by the National Council for Prescription Drug Programs (NCPDP).

The NCPDP is the standards setting organization for pharmacy claims transmission and is recognized by insurers, pharmacy benefits managers, and pharmacy groups. The NCPDP has identified information that must be included on information cards in order for claims to be successfully transmitted and has developed an implementation guide show how the essential elements must be positioned on the card to insure uniformity. In the process of developing the standard elements the NCPDP has worked with the National Committee for Information Technology Standards (NCITS), a group that is developing a uniform health care identification card standard and with the American National Standards Institute (ANSI). ANSI has approved the health care ID card standard and the NCPDP standard incorporates those elements.

The NCITS has three required data elements (Issuer, ID, and Name) and the NCPDP implementation guide incorporates one additional required field, the BIN. There are conditional fields such as the Group Number and Processor Control Number. When these fields are required for proper claims adjudication, they are also required data elements. A sample card with required elements is shown below:

FRONT

Desired Name/Logos

RxBIN (Required)
RxPCN(Conditional)
RxGrp (Conditional)
Issuer (Number developed as a part of HIPAA)
ID **12345678901** (Required)
Name **JOHN Q PUBLIC** (Required)

BACK

Pharmacy Help Desk: (800) 555-1234
Customer Service: (800) 555-9876
Submit Claims to.
Any Pharmacy Benefits Manager
123 ABC Street
Anytown, MO 00000-0000

This Act does provide some discretion to the Insurance Commissioner. If insurers or plans would require data elements that are not specified as required or optional under the NCPDP guide, the commissioner would approve the format. In addition if for some reason the NCPDP standards would be replaced by some other national standard, the Insurance Commissioner would be able to accept that format.

Sub-section 3. describes when new information cards would be issued. There is no requirement that an insurer or plan replace current cards in place. The Act allows replacement of cards when a plan normally reissues cards or when there are plan changes that require changes in the data the pharmacies must use to transmit claims. The Act even allows the insurers or plans to use stickers to update the cards when there are changes made, without having to issue new cards. There should be very minimal expense because new cards are not required. The only costs would result from reformatting the way already variable information is printed on the cards.

Sub-section 4. allows the information card to be used for any health insurance coverage. The NCPDP Implementation Guide has several formats that can be used to effectively combine prescription information and medical identification information on the same card. There is no requirement for separate prescription information cards and there should be no additional costs because new cards are required.

Section 2. This section requires the PERS Board to provide uniform information cards. PERS has prepared a fiscal note indicating that the Act will have no fiscal impact on the Board.

The current system that pharmacists and patients must currently deal with is not working and we continually hear about more problems. I have included a card that David Olig, the owner of Southpointe Pharmacy in Fargo, submitted to us as an example.

The insurance industry may ask why we are asking for these standards in law rather than working on a voluntary basis. The NCPDP standard was supposed to be voluntary. However work began on the standard four years ago and large scale voluntary implementation hasn't happened. We would prefer voluntary compliance to laws but the problem is so profound for pharmacy that the issue must be pursued now. National pharmacy groups have worked with insurers for almost two years to try to get agreement and no agreement has been reached. The National Association of Chain Drug Stores has met with the Health Insurance Association of America several times to forge a voluntary approach but has not had any success.

We have reviewed alternative legislation that has been prepared by the HIAA and have rejected it because it does not follow the NCPDP standards, does not include all the entities that issue cards, and exempts certain types of plans from inclusion. We feel that in actuality the HIAA draft could lead to less uniformity among the states because it does not specifically incorporate NCPDP standards.

This bill is just not for the benefit of pharmacies. It does help consumers and even insurers by providing the following benefits:

1. Dealing with insurance issues is the single biggest problem identified by pharmacist as increasing wait times for patients.
2. This interferes with a pharmacist's ability to meaningfully interact with consumers and help them avoid problems such as med. errors identified by the IOM study.
3. Some pharmacies are actually having portable phones installed and making patients deal directly with their insurance company.
4. This decreases rejected claims and the costs associated with them.
5. This helps pharmacy, consumers and INSURERS by decreasing calls to the help desk and decreasing consumer's irritation.

You can act now by passing this legislation and joining other states to create a uniform standard that will create compliance by insurance companies and benefits managers. It will help North Dakota patients when they are in other states and have their prescriptions filled by having standard information that those pharmacies understand and use for speedy prescription adjudication. The provision for benefits managers and third party administrators will help when those entities outside the state issue information cards to patients residing in North Dakota. Passage will allow pharmacists to spend more time with patient care and less with working on insurance snarls that delay provision of medications to waiting patients. North Dakota is one piece of a national puzzle and can play a vital role if this legislation is passed.

We ask your support and yes vote on HB 1365.
Thank You

North Dakota Pharmaceutical Association

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February 20, 2001

Senator Judy Lee, Chair
Senate Human Services Committee
600 Boulevard Ave
Bismarck ND 58505

Dear Senator Lee:

I have reviewed the testimony that Brenda Blazer gave concerning HB 1365 and have investigated the NCPDP Website and HHS Website for HIPAA.

Ms. Blazer was correct when she indicated in her testimony that HHS has chosen NCPDP Telecommunications Standard Format Version 5.1 and equivalent NCPDP Batch Standard Version 1.0 has HIPAA standards for implementation on October 2002. **These standards apply only to transmission of data and do not include any information about the information that is required on prescription information cards.**

I have included a copy of the three NCPDP Standards that are referenced in the testimony presented by the North Dakota Pharmaceutical Association and by Brenda Blazer. As you can see the standards all stand separately but yet blend together to provide uniformity of data.

The fact that HHS has chosen to use NCPDP standards in its data transmission rules makes it all the more compelling for the North Dakota legislature to pass HB 1365. While the HIPAA standards will state what types of data will be standard for transmission, the HIPAA standards say nothing about how that information is supplied to pharmacies. I could find nothing in the HIPAA data transmission regulations that address Prescription Information Cards. HB 1365 provides a method to insure that pharmacies will receive the needed data elements necessary to comply with the HIPAA requirements that will be imposed. Without HB 1365, pharmacies will continue to be stuck with the cumbersome task of having to find and verify information needed to transmit pharmacy claims.

Passage of HB 1365 will speed uniformity by using the NCPDP Pharmacy ID Card Implementation Guide to give pharmacies the data necessary to transmit claims following the NCPDP Telecommunication Standard/Implementation Guide Version 5.1 and Batch Transaction Standard and Implementation Guide 1.0. After going through all information I am more convinced that passage of HB 1365 will create uniformity, not variance as claimed by HIAA. I hope this answers your questions and ask for prompt passage of HB 1365 to eliminate this vexing problem for North Dakota pharmacists and patients.

Sincerely,

Galen Jordre, R.Ph.
Executive Vice President

cc: Senate Human Services Committee Members

NCPDP Implementation Guides

Pharmacy ID Card Implementation Guide

a) What business problem is this standard trying to overcome?

- This NCPDP Pharmacy ID Card Implementation Guide is intended to provide practical guidelines for organizations or entities producing member identification (ID) cards for use in the pharmaceutical drug benefit industry and to promote a consistent implementation of the NCPDP adopted ID card standard throughout the industry.

b) How is/could this standard be used in practical, day-to-day applications?

- Pharmacists would save time entering new patients and/or new insurance information into their computer as they would readibly be able to locate the necessary information for claims processing.
- Pharmacists would not need to spend as much time on the telephone contacting PBM Help Desks for information.
- PBMs would have decreased expenses on Help Desk.
- PBMs would have decreased expenses on ID card printing because the standard format would be used.
- Patients would spend less time at the pharmacy waiting for prescriptions.

c) To whom is this standard useful (i.e. target markets)?

- Pharmacies, PBMs, payers, ID card manufacturers, Employers, state and national associations

Batch Transaction Standard and Implementation Guide

a) What business problem is this standard trying to overcome?

- Eliminates the many proprietary formats by providing one standardized file submission format to be submitted in a non-real-time mode: allows a batch to contain claims from multiple pharmacies at a centralized site to multiple processors via a switch.

b) How is/could this standard be used in practical, day-to-day applications?

- Allows a batch to contain claims from multiple pharmacies at a centralized site to multiple processors via a switch.

c) To who is this standard useful (i.e. target markets)?

- Anyone who wants to communicate an electronic pharmacy transaction.

Telecommunication Standard / Implementation Guide Version 5 Release 1

What business problem is this standard trying to overcome? The new standard has numerous benefits and advantages over the existing NCPDP telecommunication standards. Some of the benefits and advantages are:

- Expanded dollar fields
- HIPAA supported fields including Employee ID, Payer ID, and Prescriber ID
- New clinical fields including expanded Diagnosis Code, Patient Height, and Patient Body Surface Area
- Service transactions for expanded professional pharmacy service support
- Expanded coordination of benefits (COB) support
- Support of intermediary processing
- Coupon fields
- Expanded response messaging including preferred product support and approved message codes
- Flexibility with qualifiers that allows for addition of qualifier type codes instead of adding new fields
- Pricing uniformity
- Controlled Substance reporting support including Alternate ID and Scheduled Rx ID
- Consistency within the NCPDP telecom standard
- Correction of issues from previous versions
- Generic reject error code list which is more consistent with X12 error code logic
- Variable length transactions that allows for trading partners to transmit only the data required for doing business

b) How is/could this standard be used in practical, day-to-day applications?

- An estimated 2.7 billion prescriptions are filled in the United States each year. Of these, an estimated 80% (~2 billion) prescriptions are electronically submitted to pharmacy payers using one of the NCPDP telecommunication standards.

c) To whom is this standard useful (i.e. target markets)? NCPDP Version is useful for:

- Retail and institutional pharmacies,
- Pharmacy claim processors,
- Pharmacy benefit managers & payers
  - Coupon Vendors,
  - Value Added Networks and Intermediaries, and
  - Auditors of Controlled Substance Utilization

Brenda L. Blazer
Health Insurance Association of America

TESTIMONY IN OPPOSITION TO HB 1365
Senate Human Services Committee
February 20, 2001

The Health Insurance Association of America (HIAA) is an insurance trade association representing insurance companies who write accident and health insurance on a nationwide basis. The HIAA and its members strongly oppose HB 1365 as imposing unnecessary and burdensome requirements for prescription drug cards.

The National Council of Prescription Drug Programs was organized by health insurers, health plans, pharmacists, and pharmacies to develop voluntary standards for submission of pharmacy claims. The National Association of Chain Drug Stores is now pushing for state-by-state enactment of laws that would make the voluntary standards mandatory. Such a enactment is unnecessary because of the recently promulgated HHS final rule governing electronic health care transactions pursuant to the Health Insurance Portability and Accountability Act (HIPAA). Further, a state-by-state enactment will yield a hodge podge of state laws at variance with each other and with HIPAA.

One of the major goals of HIPAA is to improve the efficiency and effectiveness of the health care system with a resulting monetary savings on health care providers and health plans from the reduction in administrative burdens. This goal will hopefully be achieved by the designation of the national standards in the final HHS rule. The HHS chose ANSI standards for all transactions except retail pharmacy transactions. The NCPDP standards were chosen for retail pharmacy transactions. Specifically, HHS chose NCPDP Telecommunications Standard Format Version 5.1 and equivalent NCPDP Batch Standard Version 1.0. These are the standards health plans will be required to be in compliance with by the effective date of October 2002.

Compliance with HHS final rule pursuant to HIPAA will be a huge undertaking. HHS recognized the complexity and burden of compliance. That is why HHS allowed two years for compliance (three years for small health plans). Insurance companies are actively working toward compliance with the multiple

aspects of the HHS final rule. Retail pharmacy transactions are just one part of the changes required of health insurance companies. The only way to make the goals of HIPAA a reality is to allow the HHS rule alone set the national standards.

Insurance companies who do business in several states cannot be faced with requirements for compliance with HIPAA and multiple state variations. To ask a multi-state insurance company to comply with a federal and multiple state requirements would be like asking Blue Cross Blue Shield of North Dakota to comply with a state as well as different county requirements.

HB 1365 mandates issuance of a prescription drug card which conforms to "the most recent pharmacy information card" OR "technology implementation guide produced by the national council of prescription drug programs" OR "a national format acceptable to the commissioner." The HHS final rule has already set the NCPDP versions to be used by health plans and health care providers on a national basis. Further, HB 1365 does not allow the 24 month compliance time frame allowed by the HHS final rule.

HB 1365 would result in significant operational and administrative costs for insurance companies with no benefit to consumers. Passage of HB 1365 would make if difficult for insurance companies with a small presence in North Dakota to justify continuing doing business in this state. The goal of the pharmacists is the same as the goals of HIPAA - uniformity. The HHS final rule sets national standards with, hopefully, resulting cost savings for health insurers and providers.

HIAA, on behalf of its members who do business in multiple states, respectfully ask the Committee to let HIPPA work and give HB 1365 a "do not pass" recommendation as unnecessary and burdensome.

Frequently Asked Questions About Electronic Transaction Standards Adopted Under HIPAA

New! Updated 9/8/2000

Questions

Answers

Why have national standards for electronic health care transactions been adopted and why are they required?

Congress and the health care industry have agreed that standards for the electronic exchange of administrative and financial health care transactions are needed to improve the efficiency and effectiveness of the health care system. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of Health and Human Services to adopt such standards.

National standards for electronic health care transactions will encourage electronic commerce in the health care industry and ultimately simplify the processes involved. This will result in savings from the reduction in administrative burdens on health care providers and health plans. Today, health care providers and health plans that conduct business electronically must use many different formats for electronic transactions. For example, about 400 different formats exist today for health care claims. With a national standard for electronic claims and other transactions, health care providers will be able to submit the same transaction to any health plan in the United States and the health plan must accept it. Health plans will be able to send standard electronic transactions such as remittance advices and referral authorizations to health care providers. These national standards will make electronic data interchange a viable and preferable alternative to paper processing for providers and health plans alike.

What health care transactions are required to use the standards under this regulation?

As required by HIPAA, the Secretary of Health and Human Services is adopting standards for the following administrative and financial health care transactions:

1. Health claims and equivalent encounter information.
2. Enrollment and disenrollment in a health plan.
3. Eligibility for a health plan.
4. Health care payment and remittance advice.
5. Health plan premium payments.
6. Health claim status.
7. Referral certification and authorization.
8. Coordination of benefits.

Standards for the first report of injury and claims attachments (also required by HIPAA) will be adopted at a later date.

Who is required to use the standards?

All private sector health plans (including managed care organizations and ERISA plans, but excluding certain small self administered health plans) and government health plans (including Medicare, State Medicaid programs, the Military Health System for active duty and civilian personnel, the Veterans Health Administration, and Indian Health Service programs), all health care clearinghouses, and all health care providers that choose to submit or receive these transactions electronically are required to use these standards. These "covered entities" must use the standards when conducting any of the defined transactions covered under the HIPAA.

A health care clearinghouse may accept nonstandard transactions for the sole purpose of translating them into standard transactions for sending customers and may accept standard transactions and translate them

into nonstandard transactions for receiving customers.

If a health plan does not perform a transaction electronically, must it implement the standard?

If the plan performs that business function (whether electronically, on paper, via phone, etc.), it must be able to support the electronic standard for that transaction. It may do this directly or through a clearinghouse.

When will the standards become effective?

All health plans, all health care clearinghouses, and any health care provider that chooses to transmit any of the transactions in electronic form must comply within 24 months after the effective date of the final rule (small health plans have 36 months). The effective date of the rule is 2 months after publication. Therefore, compliance with the final rule is required by October 2002 (October 2003 for small health plans). Entities can begin using these standards earlier than the compliance date.

Where did these standards come from? Did the Federal Government create them?

HIPAA required the Secretary to adopt standards, when possible, that have been developed by private sector standards development organizations (SDOs) accredited by the American National Standards Institute (ANSI). These are not government agencies. All of the transactions adopted by this rule are from such organizations. All are from the Accredited Standards Committee (ASC) X12N except the standards for retail pharmacy transactions, which are from the National Council for Prescription Drug Programs (NCPDP).

What standards were chosen?

ANSI ASC X12N standards, Version 4010, were chosen for all of the transactions except retail pharmacy transactions. The choice for the retail pharmacy transactions was the standard maintained by the NCPDP because it is already in widespread use. The NCPDP Telecommunications Standard Format Version 5.1 and equivalent NCPDP Batch Standard Version 1.0 have been adopted in this rule (health plans will be required to support one of these two NCPDP formats).

Do these standards apply to transactions sent over the Internet?

Internet transactions are being treated the same as other electronic transactions. However, we recognize that there are certain transmission modes in which the format portion of the standard is inappropriate. In these cases, the transaction must conform to the data content portion of the standard. In particular, a "direct data entry" process, where the data are directly keyed by a health care provider into a health plan's computer using dumb terminals or computer browser screens, would not have to use the format portion of the standard, but the data content must conform. If the data are directly entered into a system that is outside the health plan's system, to be transmitted later to the health plan, the transaction must be sent using the format and content of the standard.

Do I have to use standard transactions when conducting business inside my corporate boundaries?

The decision on when a standard must be used does not depend on whether the transaction is being sent inside or outside corporate boundaries. Instead, a simple ... test, in question form, can be used to

determine whether the standards are required.

Question 1: Is the transaction initiated by a covered entity or its business associate? If no, the standard need not be used.

Question 2: Is the transaction one for which the Secretary had adopted a standard? If yes, the standard must be used. If no, the standard need not be used.

For purposes of question 1, a business associate acting on behalf of a covered entity can only perform those particular functions that the covered entity itself could perform in the transaction. The regulation requires health plans to accept standard transactions from any person.

For purposed of question 2, the definitions of the transactions themselves, as stipulated in Subpart K through Subpart R of the regulation, must be used to determine if the function is a transaction for which the Secretary has adopted a standard.

What is the effect on State law?

Section 1178 of the Social Security Act provides that standards for the transactions will supercede any State law that is contrary to them, but allows for an exception process. This process is currently under development and will be issued in the final rule for Privacy Standards.

Are any exceptions allowed?

In addition to the exceptions for conflicting State laws, an exception may be allowed for the testing of proposed modifications to the standards. An entity wishing to test a different standard may apply for an exception to test the new standard. Instructions for applications are published in the final rule. In this way, we hope to encourage the development of new technologies.

What does the law require of state Medicaid programs?

Section 1171(5)(E) of the Social Security Act, as enacted by HIPAA, identifies the State Medicaid programs as health plans, which therefore must be capable of receiving, processing, and sending standard transactions electronically. There is no requirement that internal information systems maintain data in accordance with the standards. However, Medicaid programs will need the capacity to process standard claim, encounter, enrollment, eligibility, remittance advice, and other transactions. In addition, as health plans, the State Medicaid programs will be required to comply with other HIPAA standards two years after adoption of the standards.

The standards should benefit Medicaid programs in multiple areas. Here are a few examples:

- A national standard for encounter transactions will provide a much-needed method for collecting encounter data on Medicaid beneficiaries enrolled in managed care. Because of the standards, it will be possible to combine encounter data from managed care with similar claims data from fee-for-service, thus enhancing the ability to monitor utilization, costs, and quality of care in managed care and to compare managed care with fee-for-service.
- The standard transactions will include methods for electronic exchange of enrollment information between the Medicaid program and private managed care plans enrolling Medicaid beneficiaries. This will reduce administrative costs of exchanging such information and enhance the reliability of such information.
- The conversion to national standards provides an opportunity for Medicaid programs to shift to

commercial software or clearinghouses and to stop the expensive maintenance of old, customized transaction systems.

How will the standards be enforced?

The law gives the Secretary the authority to impose monetary penalties for failure to comply with a standard. The Secretary is required by statute to impose penalties of not more than $100 per violation on any person or entity who fails to comply with a standard except that the total amount imposed on any one person in each calendar year may not exceed $25,000 for violations of one requirement. Enforcement procedures will be published in a future regulation.

How were the standards chosen?

First, the Department developed a set of guiding principles to serve as the basis for evaluating alternative standards for each transaction. These guiding principles, designed to be consistent with the intent of HIPAA, are published in the regulation. Second, an inventory of standards was developed by the ANSI Health Informatics Standards Board, a private sector organization. Third, teams composed of representatives from several government agencies evaluated the available standards against the guiding principles to determine which standards best met the principles. Extensive outreach and consultation, including public meetings, with all facets of the health care industry continued throughout this process.

As required by HIPAA, the Secretary also consulted with the National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC), the American Dental Association (ADA), and the Workgroup for Electronic Data Interchange (WEDI). The Secretary also considered advice from the National Committee on Vital and Health Statistics (NCVHS) and representatives of the health care industry who testified before the NCVHS Subcommittee on Health Data Needs, Standards, and Security.

Data dictionaries are available for an additional fee.

Where can I obtain implementation guides for the standards?

The implementation guides for the ASC X12N standards may be obtained from the Washington Publishing Company, 806 W. Diamond Ave., Suite 400, Gaithersburg, MD, 20878; telephone: 301-949-9740; FAX: 301-949-9742. These guides are also available at no cost through the Washington Publishing Company on the Internet at http://www.wpc-edi.com/hipaa/.

The implementation guide for retail pharmacy standards is available from the National Council for Prescription Drug Programs, 4201 North 24th Street, Suite 365, Phoenix, AZ, 85016; telephone: 602-957-9105; FAX: 602-955-0749. It is also available from the NCPDP's website at http://www.ncpdp.org.

How can the standards be changed?

The Secretary has designated six organizations that have agreed to serve as Designated Standards Maintenance Organizations (DSMOs). The DSMOs are:

1. Accredited Standards Committee X12
2. The Dental Content Committee
3. Health Level Seven
4. National Council for Prescription Drug Programs
5. National Uniform Billing Committee

6. National Uniform Claim Committee

These organizations will work together to accept and evaluate requests for changes to the standards and suggest changes to the standards for the Secretary's consideration. Further information about the change request process can be found on the Internet at: http://www.hipaa-dsmo.org .

The Secretary may modify a standard or its implementation guide specification one year after the standard or implementation specification has been adopted, but not more frequently than once every 12 months. If the Secretary modifies a standard or implementation specification, the implementation date of the modified standard or implementation specification may be no earlier than 180 days following the adoption of the modification. The Department of Health and Human Services (HHS) will determine the actual date, taking into account the time needed to comply given the nature and extent of the modification. HHS may extend the time for compliance for small health plans. Standards modifications will be published as regulations in the Federal Register.

Does the law require physicians to buy computers?

No, there is no such requirement. However, more physicians may **want** to use computers for submitting and receiving transactions (such as health care claims and remittances/payments) electronically, once the standard way of doing things goes into effect.

The Administrative Simplification provisions of the HIPAA law were passed with the support of the health care industry. The industry believed standards would lower the cost and administrative burdens of health care, but they needed Government's help to get to one uniform way of doing things. In the past, individual providers (physicians and others) have had to submit transactions in whatever form each health plan required. Health plans could not agree on a standard without giving their competitors a market advantage, at least in the short-run. The law, which requires standards to be followed for electronic transmission of health care transactions, levels the playing field. It does not require providers to submit transactions electronically. It does require that all transactions submitted electronically comply with the standards.

Providers, even those without computers, may want to adopt these standard electronic transactions, so they can benefit directly from the reductions in cost and burden. This is possible because the law allows providers (and health plans too, for that matter) to contract with clearinghouses to conduct the standard electronic transactions for them.

How will the standards affect data stored in my system?

The transaction standards will apply only to electronic data interchange (EDI) -- when data are transmitted electronically between health care providers and health plans as part of a standard transaction. Data may be stored in any format as long as it can be translated into the standard transaction when required. Security standards, on the other hand, will apply to all health care information.

To comply with the transaction standards, health care providers and health plans may exchange the standard transactions directly, or they may contract with a clearinghouse to perform this function. Clearinghouses may receive non-standard transactions from a provider, but they must convert these into standard transactions for submission to the health plan. Similarly, if a health plan contracts with a clearinghouse, the health plan may submit non-standard transactions to the clearinghouse, but the clearinghouse must convert these into standard transactions for submission to the provider.

Can health plans require changes or additions to the standard claim?

Currently, some insurers accept the de facto standard claim (e.g., UB-92) but also require additional records (e.g., a proprietary cover sheet) for each claim submitted. Others have special requirements for data entered into the claim which make it non-standard.

Under the law, health plans are required to accept the standard claim submitted electronically. They may **not** require providers to make changes or additions to the standard claim. They must go through the private sector standards setting process to get their requirements added to the standard in order to effect desired changes. Health plans may not refuse the standard transaction or delay payment of a proper standard transaction.

An additional standard will be adopted for electronic health claims attachments, which health plans will be required also to accept. Until that standard is adopted (by February, 2001), health plans may continue to require health claim attachments to be submitted on paper. No other additions to standard claims will be acceptable.

Should health plans publish companion documents that augment the information in the standard implementation guides for electronic transactions?

Additional information may be provided within certain limits.

Electronic transactions must go through two levels of scrutiny:

1. *Compliance with the HIPAA standard.* The requirements for compliance must be completely described in the HIPAA implementation guides and may not be modified by the health plans or by the health care providers using the particular transaction.
2. *Specific processing or adjudication by the particular system reading or writing the standard transaction.* Specific processing systems will vary from health plan to health plan, and additional information regarding the processing or adjudication policies of a particular health plan may be helpful to providers.

Such additional information may not be used to modify the standard and may not include:

- Instructions to modify the definition, condition, or use of a data element or segment in the HIPAA standard implementation guide.
- Requests for data elements or segments that are not stipulated in the HIPAA standard implementation guide.
- Requests for codes or data values that are not valid based on the HIPAA standard implementation guide. Such codes or values could be invalid because they are marked not used in the implementation guide or because they are simply not mentioned in the guide.
- Change the meaning or intent of a HIPAA standard implementation guide.

Could companion documents from health plans define cases where the health plan wants particular pieces of data used or not used?

The health plan must read and write HIPAA standard transactions exactly as they are described in the standard implementation guides. The only exception would be if the guide explicitly gives discretion regarding a data element to a health plan. For claims and most other transactions, the receiver must accept and process any transaction that meets the national standard. This is necessary because multiple health plans may be scheduled to receive a given transaction (e.g., a single claim may be processed by multiple health plans).

For example: Medicare currently instructs providers to bill for certain services only under certain circumstances. Once HIPAA standard transactions are implemented, Medicare will have to forego that policy and process all claims that meet HIPAA specifications. This does not mean that Medicare, or any other health plan, has to change payment policy. Today, Medicare would refuse to accept and process a bill for a face lift for cosmetic purposes only. Once the HIPAA standards are implemented, Medicare will be required to accept and process the bill, but still will not pay for a face lift that is purely for cosmetic purposes.

May health plans stipulate the codes or data values they are willing to accept and process in order to simplify implementation?

The simplest implementation is the one that is identical to all others. If the standard adopted stipulates that HCPCS codes will be used to describe procedures, then the health plan must abide by the instructions for the use of HCPCS codes. A health plan could refuse a code that was not applied in accordance with the HIPAA national standard coding instructions, but could not refuse a code properly applied for reasons of policy unrelated to the standard.

For example, if the standard stipulates that the most specific code available must be used, then a health plan would be right to refuse a code that does not meet that criterion. The health plan would need to work with the committee(s) governing the particular coding scheme to have codes adopted that meet its needs.

May health plans stipulate the number of loop iterations or the file sizes they are willing to accept?

Any loop iterations, file sizes, etc. stipulated in the standards must be honored by all players. If any health care electronic data interchange participant cannot live with the numbers stipulated in the HIPAA implementation guides, then the participant needs to work with the implementation guide author(s) to get numbers that all players can live with

For example, there are up to 99 service lines in a professional claim. The provider need not write 99 service lines, but the health plan must have the capability to accept that number when presented. If that is not the right number for all players, it should be changed. But the number identified in the implementation guide must be adhered to.

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News

HIPAA UPDATE: FINAL RULING NAMES 5.1 AS OFFICIAL STANDARD

On August 11, 2000, the final rule was displayed on the Department of Health and Human Services Administrative Simplification website. The final rule, which will be published in the Federal Register by August 17, 2000, adopts NCPDP Telecommunication Standard Format, Version 5.1 in place of Version 3.2 for pharmacy claims. The final rule also listed numerous benefits of using Version 5.1 over Version 3.2, including the incorporation of HIPAA supported fields, the expanded coordination of benefits (COB) support, and the variable length transactions that allow for trading partners to transmit only the data required for doing business.

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