

**Report of the  
Committee on Electronic Data Exchange  
Pursuant to HB 522  
Eightieth Legislature, Regular Session,  
2007**



**Report and Recommendations  
Relating to the Facilitation of  
Electronic Health Insurance Data  
Exchange**

**December 2008**

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## II. EXECUTIVE SUMMARY

Pursuant to HB 522, the Department of Insurance asked a number of technical experts in the health insurance and health care industries to come together to work on the issue of getting providers access to real time health insurance eligibility information in a manner which would genuinely benefit providers, insurers, and consumers.

The Committee met numerous times over the course of 2007 and 2008, gathering information and considering technology options. Ultimately, some primary issues came to the forefront and guided the Committee's recommendations. Immediately apparent were the existence of new national standards for health identification (ID) cards and electronic data exchange and the question of whether those standards would adequately meet Texas' needs. The Committee ultimately concluded that the existing national standards create an opportunity to move the healthcare and health insurance industries forward, at least incrementally, toward a nationally standardized system that could be readily adopted by providers, insurers, and the technology providers that support them, such as software developers.

Regarding the format and content of ID cards, the Committee recommends adopting the standard adopted in November of 2007 by the Workgroup for Electronic Data Interchange (WEDI). That standard sets forth required printed information, but primarily focuses upon standardizing the location of that printed information. The WEDI standard also sets standards for machine readable information on the card through the use of magnetic stripes or bar codes.

Regarding eligibility verification, the Committee noted that the federal government is working on enhancing its standards under the Health Insurance Portability and Accountability Act (HIPAA) for electronically exchanging eligibility information, but ultimately decided against recommending that Texas duplicate the federal regulations. Instead, the Committee recommends that

Texas adopt the national standards adopted by the Council on Affordable Quality Healthcare (CAQH), the CORE Phase I standards. The CORE Phase I standards build on the current federal regulations but set higher standards, particularly with respect to the information required to be returned by insurers in response to requests for eligibility information.

The Committee also took note of the current and upcoming developments in ID card technology and eligibility verification, such as the issuance of millions of machine readable ID cards in Texas, new federal regulations on eligibility verification, and new Texas initiatives related to electronic data exchange. In light of the rapid changes in this area, the Committee also recommends that the state continue to examine what regulations should be adopted relating to these issues, the progress and success of insurers' efforts to promote electronic data exchange, other options for improving electronic data exchange, and methods for encouraging provider adoption of these new technologies.

### **III. BACKGROUND - HB 522 and the State of the Industry**

#### **A. The Committee**

Pursuant to House Bill 522, enacted by 80th Legislature, the Commissioner of Insurance appointed an advisory committee in 2007 to make recommendations on standardization of health insurance identification (ID) cards and standards for electronic data exchange to enable providers to obtain real time, robust eligibility information. Below are the current members of the HB 522 Committee on Electronic Data Exchange (CEDE).

<b>Committee Members</b>	<b>Affiliation</b>
<b>Name</b>	
Demetria Qualls	Baylor College of Medicine
Ejay J. Birkmeyer	University of Texas Medical Branch at Galveston
Eric Cahill	Aetna
James E. Adams	University of Texas Southwestern Medical Center at Dallas
Suzanne Webb	Tenet Healthcare Corporation
Janet Gilmore	Texas Department of Information Resources
Jeffrey Mark Jekot, M.D.	Austin Anesthesiology Group, L.L.P.
John Tietjen	University of Texas M.D. Anderson Cancer Center
Joseph M. Taylor	Blue Cross Blue Shield of Texas
Katherine Pat Conover	Texas Tech University Health Sciences Center School of Medicine
Ken Masslon	Exante Financial Services
LaRea Albert	HealthFirst Third Party Administrators
Manfred Sternberg	Bluegate Corporation
David Renfro	Availity, LLC
Millie Marlow	Texas Department of Information Resources
Patricia Reeves	HealthMarkets, Inc.
Peter Walker	Aetna
Scott Frederick Schoenvogel	Baylor Health Care System
Stanwood Mooney	Jl Companies
Steve Browning	Texas Health Insurance Risk Pool
Troy Stillwagon	Scott and White Health Plan
Deeia Beck	Office of Public Insurance Counsel

The committee has had fourteen meetings, as well as many email exchanges. TDI staff has also met and discussed the project numerous times with stakeholders in the payer, provider, and clearinghouse communities. The purpose of the CEDE meetings has generally been to obtain information about the current state of the industry regarding ID cards and electronic data exchange and where the industry is going, and to discuss potential requirements for ID cards and eligibility verification. There has been extensive discussion of various national and local initiatives in these areas by national bodies, Texas carriers, and others.

## **B. Pilot Projects**

In conjunction with the HB 522 committee meetings, TDI staff has worked a great deal on the aspect of HB 522 that calls for a pilot project in which carriers in selected counties would issue ID cards with new technology that would assist with electronic eligibility verification. TDI staff has drafted and circulated several versions of rules to create a mandatory ID card pilot. Through the committee meetings and discussions with various stakeholders; however, staff and the committee found that three of the largest carriers in the state already had ID card projects in place and that national standards for machine readable ID cards were adopted in November of 2007. Due to these factors, as well as consideration of potential costs, TDI postponed the implementation of a state mandated pilot in favor of the projects already being conducted.

Blue Cross and Blue Shield of Texas, Humana, and United Healthcare are currently involved in robust ID card projects in Texas. These three carriers have already completed a successful joint pilot project in Florida in which they distributed magnetic stripe readers to providers and provided free access to a clearinghouse named Availity LLC, which could accept information read from a card swipe and provide real time eligibility information, as well as other information, to providers. Humana expects to transition all of its Texas ID cards to magnetic stripes in 2009, while Blue Cross expects to have over a million such cards issued in selected areas of the state in 2009. United Healthcare has been providing cards with magnetic stripes since 2004, and currently all of their commercial cards issued in Texas have a three track magnetic stripe, which can be used over proprietary and open systems to get eligibility information. Card readers have also been distributed to numerous providers' offices.

These pilot projects have demonstrated that machine readable ID card systems can work. As discussed below, voluntary national standards have been

adopted for the machine readable elements of insurance ID cards. The carriers mentioned above have demonstrated that magnetic stripe cards, a long used technology, can work when swiped through simple card readers. They have also shown that their online software systems are capable of providing electronic eligibility data. The issue that has generally arisen has been whether these systems are sufficiently beneficial to providers that they will be generally adopted by that group.

Additionally, TDI received comments from several carriers that a limited pilot, testing the ability to obtain real time eligibility information through the use of machine readable ID cards, was not technologically feasible. Carriers reported that they generally do not make changes to their electronic systems on a single county level. If TDI mandated real time electronic transaction standards industry wide in a single county, carriers reported that they would have to make very significant system-wide changes to their software, which would affect more than one county. Also, in light of the several national initiatives discussed below, it appeared that any potential pilot standards implemented by TDI would cause significant costs to carriers, would not be limited to a single county, and would become quickly outdated as new national standards were released.

The WEDI standards were the result of lengthy discussions among representatives of all areas of the healthcare and insurance industries. The ID card formats recommended by WEDI, such as the magnetic stripe and PDF barcode, are well tested and have been used in different industries over a long period of time. As such, additional testing of the formats through a pilot appears unnecessary at this time.

### C. State of the Industry – ID Cards

In November of 2007, the WEDI adopted standards for ID cards, including requirements for machine readable elements. WEDI is a broad-based national coalition of almost 350 entity members representing providers, health plans, clearinghouses, trade associations, information technology system vendors, and government entities involved in the health care industry and “partnering for electronic delivery of information in healthcare.”

The WEDI ID card standards allow for two types of machine readable formats – magnetic stripes<sup>1</sup> and/or PDF barcodes. To date, staff has been unable to find evidence of any health insurer in the country using any machine readable elements other than these two types. For health insurance, as opposed to prescription coverage, carriers appear to only be using the magnetic stripe. There does not appear to be any inclination by the carriers to move away from the magnetic stripe format, although some carriers question whether machine readable elements are necessary at all, as discussed below.

The WEDI standard is set forth in its Implementation Guide, which is available on the web.<sup>2</sup> The guide stresses WEDI's intent to have ID cards serve as

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<sup>1</sup> Magnetic stripes are commonly used on ID cards. They are often divided into two or three “tracks.” The first track has traditionally been used by the International Air Transport Association. Track two has been used by the American Banking Association, for automatic teller machines and point of sales devices. Track three was originally to be used by the thrift industry and mints, but has not been implemented. Normally the card is “swiped” through a card reader. Readers used for credit or debit transactions today are often only able to read two tracks, but three-track readers are common and cost between \$30 and \$60. The text/data obtained from the magnetic stripe is normally stored in the attached computer’s keyboard buffer as if it had been typed in by hand. According to one presentation to the Committee, swiping results in user correctable errors approximately 1 percent of the time, while manually keyed in information has errors approximately 20 percent of the time.

<sup>2</sup> The WEDI guide may be viewed here: [www.wedi.org/snip/public/articles/WEDI-Health-ID-Card-Approved.pdf](http://www.wedi.org/snip/public/articles/WEDI-Health-ID-Card-Approved.pdf). It incorporates an underlying American National Standard Institute (ANSI) technical standard, *Identification Cards – Health Care Identification Cards*, INCITS 284, as revised.



access keys, rather than as information storage devices. Arguments for using cards as access keys include:

1. Providers will usually request current information from the patient or the carrier rather than relying on the information stored on the card. This is because providers want current insurance information, rather than potentially out-dated information that was correct at the time the card was originally issued.
2. Storing personal health information on a card presents more security risks than storage in a carrier's database, available only through password protected access.
3. Storing large amounts of information on a card would be more expensive both in terms of the cost of the storage device on the card, and the cost of the card readers.

Though pharmacy cards are not directly the subject of HB 522, it is relevant to note that a separate national organization, the National Council for Prescription Drug Programs (NCPDP) has created standards for ID cards for use in the pharmaceutical drug benefit industry. Like the WEDI standards, the NCPDP standards are based upon the ANSI INCITS 284, "Identification Card - Health Care Identification Cards" standard. NCPDP determined that the standard magnetic stripe could not adequately accommodate all mandatory and situational data elements called for in the implementation guide, such as ANSII IIN or NCPDP issued BIN, Processor Control Number, Group Number, Card Issuer Identifier, Cardholder ID Number and Cardholder Name. The needed number of characters for these elements would not fit within the 82-character limit of a magnetic stripe track. In the future, the pharmacy industry may adopt a single identifier for appropriately routing electronic transactions. Such an identifier might be a HIPAA-specified or other industry-adopted "plan ID". Until this occurs, a larger capacity machine-readable technology is required for pharmacy claims, and NCPDP adopted the PDF417 two-dimensional barcode

symbology as this technology. The PDF417 bar code image must include the data elements needed to identify the cardholder and the card issuer as defined in the implementation guide.<sup>3</sup>

#### **D. State of the Industry – Eligibility Information**

##### **1. Federal Standards - ASC X12N (4010)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of Health and Human Services to adopt electronic data exchange standards for the health insurance industry. In 2000, the Secretary adopted final transaction standards and code sets, addressing seven particular types of common transactions by adopting the ASC X12N Version 4010. The eligibility transaction standards (270/271) were one of those transactions for which standards were adopted. The 270/271 standards had been developed independently by the Eligibility Work Group within the Insurance Subcommittee of X12, which is an accredited standards committee under ANSI.

While the 270/271 standards set a low floor in terms of what information carriers are required to provide, they also standardize and provide the only permitted methods for exchanging more complex (though optional) information. For example, while the 270/271 standards require that a 271 payer response to a 270 inquiry from a provider indicate whether the enrollee has active or inactive coverage, the standards do not mandate a coverage response for particular service codes nor additional information about the coverage, such as co-payments or deductible amounts. However, the 270/271 standards contain a complete listing of service codes and provide the format for providing more

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<sup>3</sup> For more information on magnetic stripe restrictions and PDF417 technology decisions made by NCPDP, see the NCPDP HEALTH CARE IDENTIFICATION CARD PHARMACY AND/OR COMBINATION ID CARD IMPLEMENTATION GUIDE VERSION 2.0 Section 5.5 MACHINE-READABLE FORMATS.

information about coverage for those carriers who choose to provide such information.

## **2. CAQH Standards - CORE Phase I**

CORE was created in 2005 by the Council on Affordable Quality Healthcare (CAQH), a nonprofit alliance of health plans and trade associations. CORE is a multi-stakeholder initiative representing more than 100 companies, including providers, health plans, clearinghouses, trade associations, and information technology system vendors. Under CORE, organizations voluntarily pledge to follow the CORE operating rules and undergo third party certification. CORE certification also applies to vendors and large providers to ensure that transactions work from end to end.

In 2006, CAQH published a study of the impact of conducting eligibility verifications electronically. The study of data from providers in California found that almost half of all claims rejections are due to patient identification issues. These rejections represent 2 percent of all claims submitted. The study also found that there were significant cost savings from using electronic methods of eligibility verification versus methods such as phone inquiries.

Many providers were dissatisfied with the minimal information some carriers were providing in their HIPAA-compliant 271 responses. As a result, in 2006, some of the data that is allowed (but not mandated) by the 270/271 standards was designated as “required” by the Committee on Operating Rules for Information Exchange (CORE).

CORE’s Phase I operating rules, adopted in 2006, utilize the X12 HIPAA 270/271 transaction standards while also establishing complementary business rules for system connectivity, real-time processing, security, availability, response times, and acknowledgements. Under the Phase I rules, there are

minimum standards for confirming a patient's health plan and coverage for certain service types, such as medical care, hospital inpatient, and pharmacy. The CORE Phase I operating rules also require basic information about co-payment, base deductible, and co-insurance amounts.

#### Summary of CORE Phase I Rules 150 - 157

- Rule 150 – Eligibility and Benefit Batch Acknowledgement Rule (governs messages to be sent when a batch inquiry is rejected or accepted).
- Rule 151 – Eligibility and Benefit Real Time Acknowledgement Rule (governs messages to be sent when a real time inquiry is rejected or accepted).
- Rule 152 – Eligibility and Benefit Real Time Companion Guide Rule (provides a standardized template for payer eligibility and benefit companion guides, in which payers describe requirements for submitting eligibility requests).
- Rule 153 – Eligibility and Benefits Connectivity Rule (provides standards for batch and real time transactions, including the exchange of security identifiers, errors, and acknowledgements).
- Rule 154 – Eligibility and Benefits 270/271 Data Content Rule (provides standards for 270 inquiries and 271 responses, including the dates of eligibility and the patient financial responsibility in terms of co-insurance, co-payment, and deductible amounts for each specified benefit at the base contract amounts for both in-network and out-of-network).
- Rule 155 – Eligibility and Benefits Batch Response Time Rule (provides standards for the maximum response time when processing in batch mode, generally requiring a response the next business day).
- Rule 156- Eligibility and Benefits Real Time Response Time Rule (provides standards for the maximum response time when processing in real time mode, generally requiring a response within 20 seconds).
- Rule 157 – Eligibility and Benefits System Availability Rule (provides minimum amount of time the eligibility system must be available, generally 86 percent of the time).

Currently, at least 47 entities are CORE Phase I certified, including carriers (such as Aetna, WellPoint, and Humana), clearinghouses, and providers.<sup>4</sup>

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<sup>4</sup> A complete list of entities who endorse CORE and who have been certified by CORE may be found here: [www.caqh.org/CORE\\_phase1.php](http://www.caqh.org/CORE_phase1.php).

### **3. CAQH Standards - CORE Phase II**

In July of 2008, CORE adopted its Phase II rules, which focus on the data content carriers must provide to providers if they are CORE-certified. For example, the Phase II rules provide for reporting of more specific patient liability information, such as remaining deductible amounts. The Phase II rules also provide for eligibility information on 39 additional service codes, beyond the 9 service codes required in the Phase I rules. The Phase II rules also enhance connectivity and interoperability standards, provide for better patient identification, provide standardized error codes reporting and require the reporting of claim status (X12's 276/277 transactions). The Phase II rules also contain some elements that go beyond claim eligibility. For instance, the rules include provisions regarding claim status transactions related to the federal 4010, 276/277 claim status transactions. The following Phase II rules appear to relate directly to eligibility verification:

#### Summary of CORE Phase II Rules 258-270

- Rule 258 – Normalizing Patient Last Name Rule (standardizes last names, such as through the deletion of additional characters).
- Rule 259 – AAA Error Code Reporting Rule (standardizes error responses when a carrier is unable to identify the insured).
- Rule 260 – Eligibility and Benefits (270/271) Data Content Rule (requires remaining status and base and remaining patient financial responsibility amounts for the 9 Phase I service type codes and an additional 39 other codes).
- Rule 270 – Connectivity Rule (addresses message envelope metadata, envelope standards, submitter authentication standards for both batch and real time transactions, and communications-level errors and acknowledgements).

### **4. Federal Standards - ASC X12 (5010)**

Additionally, in August of 2008, the US Department of Health and Human Services published a proposed rule to adopt updated ASC X12 HIPAA standards, from Version 4010 to Version 5010. This will include updating the 270/271 standards. Among other things, the new standards are expected to

“raise the bar” by adopting some of the non-mandated aspects of the standard that are required aspects under the CORE Phase I rules.

The 5010 270/271 standards call for payers to report specific coverage information, such as the name of plan coverage, beginning effective date, benefit effective dates, and primary care provider where available. The new standards also add nine categories of benefits that must be reported if they are available to the patient and 38 additional patient service type codes.<sup>5</sup>

## **5. Texas Medicaid Access Card Project**

A Texas initiative currently in development is the Texas Medicaid Access Card Project by the Texas Health and Human Services Commission (HHSC). While that project originally contemplated the use of ID cards with microchips containing fingerprint data for enhanced security of Medicaid transactions, HHSC has indicated that it may be moving toward the WEDI standard for machine readable ID cards in the request for proposal it expects to issue soon. HHSC has also indicated it may allow bidders for its Access Card contract to permit use of the Medicaid eligibility verification system by commercial insurers. This would allow providers to use the same system for all of their eligibility transactions. HHSC anticipates distributing up to 15,000 readers for the ID cards. In addition to providing eligibility information, the project is also to serve as an electronic health records system to provide access to transaction data, claims data, encounter data, vendor drug information, THSteps information, and immunization data.<sup>6</sup>

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<sup>5</sup> The notice of the proposed rule adopting the 5010 standards may be viewed here: [edocket.access.gpo.gov/2008/pdf/E8-19296.pdf](http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf), and the standards themselves may be purchased here: [store.x12.org/](http://store.x12.org/).

<sup>6</sup> A report on the Medicaid smart card pilot has been published here: [www.hhsc.state.tx.us/OIE/MIP/020907\\_MAC\\_IE\\_Final\\_Report.pdf](http://www.hhsc.state.tx.us/OIE/MIP/020907_MAC_IE_Final_Report.pdf).

## **6. Texas Health Services Authority (THSA)**

HB 1066 (80<sup>th</sup> Leg.) added Chapter 182 to the Health and Safety Code and established the Texas Health Services Authority “as a public-private collaborative to implement the state-level health information technology functions identified by the Texas Health Information Technology Advisory Committee by serving as a catalyst for the development of a seamless electronic health information infrastructure to support the health care system in the state and to improve patient safety and quality of care.” The corporation was authorized to:

- establish statewide health information exchange capabilities,
- promote definitions and standards for electronic interactions statewide,
- establish statewide health information exchange capabilities for streamlining health care administrative functions including “real-time communication of enrollee status in relation to health plan coverage, including enrollee cost-sharing responsibilities,” and
- “identify standards for streamlining health care administrative functions across payors and providers, including electronic patient registration, communication of enrollment in health plans, and information at the point of care regarding services covered by health plans”

The THSA recently issued a request for information, seeking input to identify options for its operations and financing. Some have suggested that the THSA could ultimately operate as a non-profit clearinghouse for obtaining real time eligibility information from payers, both public and commercial, through a swipe of an ID card.

## **7. Other States' Projects**

In 2008, both Colorado and Ohio passed bills regarding the standardization of ID cards. Colorado's bill, Senate Bill 08-135, calls for rules for standardized, printed information on insurance cards. It establishes a workgroup to make recommendations on standards for "technology and tools through which information may be electronically recognized, exchanged, or transmitted between carriers and providers" and on ways to simplify eligibility and coverage verification through electronic data interchange. The Colorado Commissioner of Insurance is then to adopt rules to implement standardized technology that would allow access to information regarding the applicable coverage under the plan.

Ohio's bill, Substitute House Bill 125, creates an advisory committee to make recommendations for mechanisms and standards enabling providers to determine eligibility and obtain real time adjudication of claims. The committee is to give advice on using HIPAA transaction standards and CORE standards to enable providers to generate compliant requests for eligibility and on the data elements carriers are required to make available, preferably under the CORE framework.

In Utah, a non-profit entity called the Utah Health Information Network (UHIN) has operated as a coalition of insurers, providers, and other interested parties in acting as a clearinghouse and adopting standards for data exchange since 1993. Information about UHIN may be obtained at their website, [www.uhin.com](http://www.uhin.com). UHIN recently adopted ID card standards based upon the WEDI card standards previously discussed in this report.



## **IV. RECOMMENDATIONS**

### **A. ID Cards**

Carriers are already voluntarily moving to the WEDI ID card national standards using magnetic stripe cards. No other type of card format appears to have been given serious consideration by the carriers. A stated concern with ID cards carrying large amounts of data on them has been that the information is quickly outdated, while online real time data can be more accurate and detailed. Storing additional personal data on a card also raises privacy concerns. Many advocate that the card should act as a “key” to obtaining secure, real time information online at the time of service. Insurers have indicated that they do not believe that additional security at the point of service is needed to ensure the identity of the individual receiving services.

One carrier, Aetna, stated its opposition to requirements for machine-readable elements on ID cards. Aetna reported to the Committee that it conducted a project from 1996 to 2003 in which it provided free point of service devices to HMO provider offices similar to those currently used in retail transactions to read credit card information. In this project, eligibility and referral transactions were conducted through a swipe of an Aetna magnetic stripe ID card. After issuing approximately five million ID cards with magnetic stripes for this system, Aetna found that only 0.11 percent of its eligibility transactions were being initiated by card swipes. Many eligibility checks were done prior to patient arrival and this, according to Aetna, contributed to the low use of this device. According to a survey Aetna conducted, only 20 percent of providers used eligibility transactions on the day of the patient’s visit. Also, Aetna did not believe that inputting information manually resulted in a significant number of increased keystroke errors over acquiring the information through a card swipe.

Many providers have given input on the pros and cons of various carriers' ID projects in Texas. Many providers reported having longstanding systems and procedures in place for checking eligibility in advance. This may be a result of historical limitations, since the carriers have been unable to provide real time eligibility information between the time a patient checks in and is seen by a provider. In contrast, many providers advocate that a viable system for real time eligibility checks could result in changes in the current procedures used by providers. Real time eligibility would also be useful to emergency providers, such as hospitals, where eligibility cannot be checked in advance.

Many providers see little time savings in real time verification when they have to log into different portals to get eligibility information from different payers. Currently, providers can get free eligibility information by logging into each payer's web portal or into free clearinghouses representing some payers, or they can pay a vendor to obtain the eligibility information for them from different payers. There does not yet appear to be a free and unified method of obtaining eligibility information from all payers. Some other problems reported by providers include:

- high percentages of patients not bringing their insurance cards with them,
- not enough magnetic stripe cards in the marketplace, and
- not enough useful information returned by payers (necessitating additional phone calls), and difficulty in transferring the electronically returned information into the providers' own electronic records.

The Committee recommends that Texas carriers be required to comply with health ID card standards set forth in the WEDI Health ID Card Implementation

Guide, Version 1.0, November 30, 2007, and the standards adopted by reference in that Guide, and as amended, with certain exceptions.<sup>7</sup>

The Committee recommends that all Texas ID cards continue to comply with all existing Texas regulations relating to required data elements on health insurance cards. Regarding machine readable information, the Committee recommends that any such information put on cards be required to comply with the WEDI standards. Legacy electronic data formats as of the date of the adoption of the Texas ID Card regulations should be permitted as specified in the WEDI Guide, with the effective date of the Texas regulations controlling. The Committee also recommends that additional technologies, such as microchips be allowed on ID cards, so long as they also contain the machine readable information prescribed by WEDI.

However, the Committee was unable to reach consensus on whether machine readable information should be required for all cards.

## **B. Eligibility Verification**

Regarding eligibility verification, the primary issues appear to be whether to recommend requiring compliance with the CORE Phase I requirements, the Phase II requirements, and/or the upcoming 5010 standards. Each level of functionality and detail required of carriers has a corresponding benefit to providers and a cost to carriers.

The Committee recommends a phased-in adoption of eligibility verification standards, with the adoption time frames varying based upon the size of the

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<sup>7</sup> It must be noted that the health insurance market in Texas is roughly equally divided into three groups: government plans (such as Medicare, Medicaid, and plans covering government employees), self-funded employer plans exempt from state regulation, and commercial individual and group insurance plans. Currently, only commercial insurance plans are regulated by the Department. The Committee recommends that the WEDI standards be applied broadly to ensure rapid adoption by the provider community.

carrier. This would correspond with HIPAA, which permits carriers with annual receipts of \$5 million or less to have an additional year to comply with new standards.

In light of the fact that the 270/271 eligibility transaction standards found within ASC X12N Version 4010 are currently required and enforced under federal law, the Committee does not recommend adopting the 270/271 standards as a state law requirement. However, the Committee does recommend requiring compliance with the CORE Phase I standards. The Committee recommends that carriers be required to comply with the CORE Phase I, Rules 150-157. Due to the technological difficulties involved in complying with the CORE standards, carriers should be given an extended amount of time to come into compliance. The Committee was unable to reach a consensus on specific timeframes for compliance. Regardless of when compliance is required, provision should be made to modify the requirements as the CORE rules change in response to any new federal requirements in the 5010 standards.

## CORE Phase I

The CORE Phase I rules are broken into two sections. Policies are discussed in rules 100 – 105, while operating rules are set forth in rules 150-157. The policies contained in rules 100 – 105 regard obtaining certifications of compliance from CORE, testing, fees, and enforcement. The policies also contain the guiding principles upon which the CORE rules are based and requirements for participants to pledge to adopt, implement, and comply with the rules.

In deciding whether to recommend adoption of the CORE rules, the Committee was constrained by the language of HB 522, as reflected in sections 1660.054 and 1660.055 of the Insurance Code, which require that the Committee “consider” information exchange framework and transactions standards

adopted by CORE, but also require that the Committee's recommendation "not endorse or otherwise confine health benefit plan issuers and administrators to any single product or vendor." In light of this, the Committee has declined to recommend adoption of the CORE rules 100-105, since this would mandate certification by a particular entity. However, the Committee does recommend adoption of the remaining operating rules for purposes of consistency of eligibility transactions across carriers, except to the extent the operating rules require CORE certification. Of course, the CORE operating rules should be interpreted in light of, and consistent with, the principles set forth in the policy rules.<sup>8</sup>

Despite the endorsement prohibition, the Committee recognizes the value of the CORE rules as a whole and suggests that an approach could be taken such as is seen in the Insurance Code provisions on quality assurance. Section 847.005, for instance, provides that a carrier is presumed to be compliant with state statutory and regulatory requirements if the carrier has received nonconditional accreditation by a national accreditation organization and the national organization's accreditation requirements are the same, similar, or more stringent than Texas' requirements. This would presumably give carriers an incentive to pursue CORE certification while also conserving state regulatory resources by permitting a presumption of compliance when certification is obtained.

## CORE Phase II

The Committee was unable to reach consensus on a recommendation regarding adoption of the CORE Phase II rules. Providers expressed that the more robust eligibility information, such as remaining deductible amounts, would be useful to them, while payers advocated that the benefits would be

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<sup>8</sup> For instance, though the operating rules set forth standards for both batch and real-time transactions, Rule 102 states that if an entity does not support batch transactions, it is not required to comply with the batch rules.

outweighed by the technology costs. However, there was agreement that compliance with the Phase I rules would likely require more time and effort from payers than the next step of compliance with the Phase II rules.

### **C. Connecting the ID Card to the Eligibility Information**

One significant issue remains for debate; whether to regulate how the card “connects” to the eligibility transaction. Providers appear to prefer a single method for obtaining information from all payers, as opposed to querying each payer through different methods or payer web portals. Currently, there is not a centralized method for obtaining eligibility information from all payers, though various private practice management software vendors, as well as clearinghouses, are moving in this direction.

The Committee finds that a centralized process for the routing of eligibility verification transactions would be beneficial to the provider community. Similar to the Utah Health Information Network ([www.uhin.com](http://www.uhin.com)), Texas could direct the creation of a non-profit entity to handle such inquiries. Potentially, the Texas Health Services Authority could serve in this role, or the state could contract with a private vendor to act as the centralized routing entity. Alternatively, the state could set forth the eligibility standards discussed above and then allow the market to work towards connectivity solutions. The Committee was unable to reach a consensus on this issue.

### **D. Future Activities of the Committee**

HB 522 provides that the Committee is to submit this report, and does not contemplate activities of the Committee after December 1, 2008. However, the Committee notes that voluntary adoption by a number of large carriers of magnetic stripe ID cards will only really begin to impact the market in 2009. The Committee believes that the Department could conduct data collection in

2009 that would permit a more realistic analysis of the benefits of machine readable ID cards and that additional committee meetings might be useful to analyze such data. If desired, the Committee could also examine potential methods for encouraging provider adoption of the new technologies.

Regardless of what regulations regarding eligibility verification are adopted in Texas, it is likely that they will be impacted by the potential adoption of the 5010 standards at the federal level. Also, CORE is currently in the draft phase of its Phase III rules. Additional committee meetings might be useful in making recommendations regarding necessary changes to Texas law in light of the federal regulations and other continuing advancements in this area. The Committee could also explore methods of encouraging provider and vendor adoption of technologies for verifying eligibility.

For these reasons, the Committee recommends that its activities be continued at least through 2009, either by statute or by transition to an informal working group created by the Department.