

CAQH CORE Phase III
Standard Health ID Card Business Case

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1 **Section I: Background**
2

3 It is an industry practice for healthcare insurance organizations or their delegated administrators to
4 provide identification (ID) cards to covered individuals. Currently, there is little uniformity and
5 automation capability in the identification cards distributed by various stakeholders within the
6 healthcare industry. This is in stark contrast to credit and bank cards issued by the banking/financial
7 industry. Whether it is a credit, debit or automated teller machine (ATM) card, issuers emboss on
8 the front of these cards the cardholder's name, card expiration date and a number which identifies
9 both the bank and the cardholder's account number at the bank. All card issuer's place this
10 information in the same format and location. The back of the cards contain 2-track magnetic stripe
11 for encoding machine-readable information, which is the same information embossed on the front of
12 the bank card. Other specific information and capabilities may be placed on the card, such as a
13 customer service phone number and security devices, while still maintaining the card issuers' unique
14 branding schema. Achieving uniform implementation of standard machine-readable cards was a key
15 step for the banking/financial industry in realizing an efficient, automated and interoperable system
16 of exchanging information through the use of electronic transactions. The implementation of
17 standard machine-readable ID cards in the health industry would have the same beneficial impact.
18

19 Health ID cards are used by healthcare professionals to identify the card issuer (i.e., health plan) and
20 the card holder (i.e., beneficiary or dependent) to facilitate the administration of healthcare services.
21 There are an estimated 100 million health ID cards in circulation which can vary considerably in
22 physical characteristics, content, format, and technology depending upon the card issuers' individual
23 business needs and decisions. This, and other factors, pose a barrier to automation and have
24 contributed to a relatively inefficient manual process across various sectors of the healthcare service
25 industry (e.g., hospitals, professional offices) for identifying a patient and verifying healthcare
26 coverage/benefits.
27

28 Standards for health ID cards exist, but uniform industry adoption remains elusive. In 1997, the
29 American National Standard Institute (ANSI) approved the International Committee for Information
30 Technology Standards (INCITS) uniform health identification card standard, *Identification Cards -*
31 *Health Care Identification Cards, INCITS 284*. Concurrently, the National Council for Prescription
32 Drug Programs (NCPDP), Standard Identifiers Work Group formed a task group to establish a
33 standard pharmacy ID card. Ultimately, this NCPDP task group adopted the INCITS standard and
34 work began on an implementation guide (IG). The NCPDP Board approved the first release of the
35 *Health Care Identification Card – Pharmacy ID Card Implementation Guide Version 1.0* in 1998.
36 The most current published release of this guide is *Health Care Identification Card – Pharmacy*
37 *and/or Combination ID Card Implementation Guide Version 2.0*. Subsequent collaboration between
38 the Work Group for Electronic Data Interchange (WEDI) and NCPDP yielded another
39 implementation guide based on the INCITS 284 standard, which incorporates elements necessary for
40 the administration (i.e., eligibility verification, claims processing, etc) of medical and pharmacy
41 benefits, as well as other dual-use cards such as combined healthcare ID card and bank card. The
42 final draft of the *Health Identification Card Implementation Guide Version 1.0* was approved by the
43 WEDI Board in November 2007. From a federal regulatory standpoint, these implementation guides
44 and underlying standards are voluntary, although the Medicare Part-D Prescription ID Card
45 Guidelines are based on the NCPDP implementation guide. The underlying *INCITS 284* standard,
46 upon which both the WEDI and NCPDP IG's are predicated, is being revised by ANSI to address
47 additional considerations outlined by the WEDI and NCPDP ID card workgroups. The current

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48 WEDI and NCPDP IG specifications incorporate these additional specifications, which include the
49 addition of PDF417 technology as a storage format and removes the requirement that the card issuer
50 identifier be the HIPAA national plan identifier.
51

52 A new Committee on Operating Rules for Information Exchange (CORE) Rules Work Group
53 Subgroup will leverage the existing standards and implementation guides to help facilitate the
54 healthcare industry’s uniform adoption of standard machine-readable healthcare ID cards. While the
55 objective of a CORE Phase III Health ID Card Subgroup may be to help facilitate this adoption, the
56 question still remains, “What can or will be achieved by the standardization of ID cards in
57 healthcare?” The simple answer to that question is administrative simplification that will result in
58 reduced errors and enable increased use of automated processes. In other words, the main objective
59 of standard machine-readable ID cards, within the context of the administrative duties of healthcare,
60 is to help streamline error prone and inefficient processes that exist in the marketplace today. By
61 enabling more streamlined healthcare administrative processes, some of the benefits that can be
62 realized through the use of standard machine-readable ID cards include:
63

- 64 • Improved patient identification and eligibility verification
- 65 • Automated administrative processes
- 66 • A reduction in claim submission errors as a result of improved eligibility verification
67 processes (10-12% in some cases as cited by CAQH CORE Phase I Measures of Success¹)
- 68 • Increased efficiency
69

70 As stated, key areas throughout the healthcare administration process remain error prone and
71 inefficient. From pre-service interactions through to billing and collections, non-standardized non-
72 machine readable ID cards may introduce, directly and indirectly, opportunities for data entry errors
73 and require manual processes for both provider and health plan staff.
74

75 The diagram on the next page illustrates how the adoption of standard machine-readable ID cards
76 paired with CORE rules could improve various steps within the healthcare administration process.

¹ CAQH CORE Phase I Measures of Success Executive Summary and Industry-wide Savings Projection available at <http://www.coreconnect.org/pdf/COREIBMstudy.pdf>

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TODAY:

Inefficient & Error Prone Processes

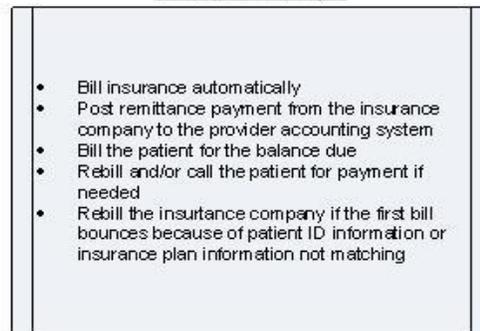
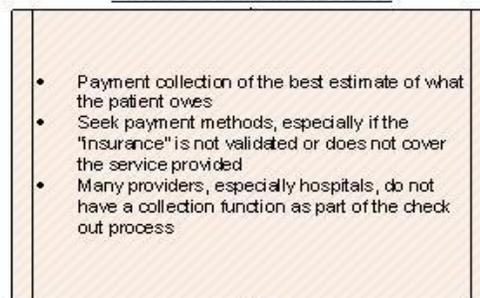
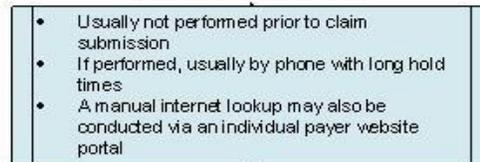
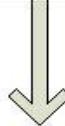
- Potential data entry errors due to miscommunication of information
- Time consuming
- Provider system may record patient name different from the insurance company

- Manual data entry
- Potential data entry errors
- Time consuming
- Patient may not have the information
- May be difficult to find the co-pay and other information on the card
- Provider system may record patient name different from the insurance company
- Data "carrying" capacity of card is limited
- Information on card is out-of-date or card is no longer valid

- Usually not performed by providers due to some of the factors above (only about 40-60% of patients are checked before or at time of service)
- When performed, often a manual process by phone or internet with manual data entry

- May not have accurate estimate of the patient responsibility amount
- Process not present in many provider settings

- Some insurance bills (claims) are rejected because the patient identification information and/or the health plan information does not match the records of the health plan
- Bills (claims) submitted to the insurance companies often are rejected because of patient identification or plan information that does not match, or the service provided is not a benefit of the insurance plan. Without eligibility verification earlier in the process, this is not known until the billing process takes place
- Insurance company remittance information is posted, usually manually, to the account system and a patient statement/bill is issued to the patient
- The patient's collection cycle, long after the service has been provided, may involve mailing several cycles of patient statements and telephone calls
- Often patients find the provider/hospital and health plan statements confusing and do not understand what they actually owe



FUTURE:

Improved and Efficient Processes due to Widespread Adoption of Uniform Standard Machine-Readable ID Cards

- ID Card with uniform standard data content, layout and format
 - Reduced potential for communicating improper or inaccurate information
 - Reduction in time spent on phone as provider staff are better able to guide patient because of familiarity
 - Gives the provider the capability of using the patient's name as recorded by the insurance company

- ID Card with uniform standard data content and machine-readable capabilities
 - Partially automated data entry
 - Reduced potential for data entry errors
 - Gives the provider the capability of using the patient's name as recorded by the insurance company
 - Efficient data capture process
 - Used as access key, card provides access to more information than can be placed on card
 - Used as access key, card provides access to up-to-date information

- Perform eligibility and benefit verification electronically prior to seeing the patient
- Can enables the provider to query the patient about payment at the time of appointment scheduling, pre-registration, and/or registration
- Eliminates phone calls, including long hold times
- Facilitates collection of co-pays and other known patient responsibilities at the time of registration

- Increases the accuracy of the patient responsibility amount, especially when the annual deductible has been met or the patient has accumulated a very low amount toward a high deductible
- Assists providers to collect the patient's financial responsibility or negotiate payment methods, reducing accounts receivable and bad debt
- Timely efficient access to patient financial responsibility allows provider who are not already doing so, to begin think about a collection process as part of their checkout process

- Reduces the number of insurance bills (claims) rejected because of patient identification, patient eligibility, or health plan information not matching the records of the health plan
- Fewer patient statements have to be printed and mailed in order to collect the patient responsibility portion of the bill
- Reduces the number of followup patient phone calls questioning the provider statement and the amount owed
- Reduces provider clearinghouse fees by eliminating claims that are now being submitted more than once
- May result in an increase in patient refunds

78 **Section II: Issues to be Addressed & Business Requirements Justification**
79

80 Just as the healthcare marketplace has shaped the current process, evolving market forces both
81 necessitate and enable movement toward a more simple and efficient method of administering the
82 business aspects of healthcare (i.e., verifying patient eligibility and benefit coverage, submitting
83 claims). No longer are patients necessarily liable for a small (5-15\$) co-pay at the time of service.
84 While a majority of insured Americans receive healthcare coverage through an employer, rising
85 premiums have resulted in greater cost sharing with the employee. As a result of this shift, and as
86 new plan models are developed to contain healthcare costs (e.g., HMO referrals, high deductible
87 health plans, coinsurance), healthcare providers and health plans are operating in an ever increasing
88 complex system of benefit plan structures and variations in patient financial responsibility. Larger
89 patient out-of-pocket financial responsibility means the provider's understanding of a patient's
90 liability and collecting it at the time of service is even more important for revenue cycle management
91 than it may have been in years past.
92

93 The evolution of technologies and standardization of electronic administrative transactions under the
94 Health Insurance Portability and Accountability Act (HIPAA) provide increased efficiencies by
95 mandating certain standard electronic transactions for healthcare providers to communicate with
96 health plans. These communications include confirming patient eligibility, submitting claims,
97 tracking the status of those claims and receiving the payment remittances. The application of
98 technologies and standardization to health ID cards can also create efficiencies for the individual
99 healthcare provider, as well as reduce health care costs for all stakeholders by eliminating inefficient
100 and error prone processes.
101

102 As with any application of a technology or implementation of a standard, uniformity is critical to
103 maximizing the efficiency of those applications or implementations. Therefore, the key to
104 effectuating the results that are expected from standard machine-readable ID cards is not only in the
105 implementation, but also in ensuring uniformity of the implementation. Relative to the uniformity of
106 implementation of the INCITS 284 *Identification Cards - Health Care Identification Cards* standard
107 as specified by WEDI *Health Identification Card Implementation Guide Version 1.0* the following
108 three (3) overarching issues have been identified:
109

110 **1. Varying Applications of Technology**
111

112 Health ID cards can vary considerably in the application of technology for data storage and machine-
113 readability. Machine-readability is necessary to enable more efficient data capture of
114 cardholder/card issuer information and automate transaction processing using the standard HIPAA
115 transactions. Relatively simple health ID cards intended to convey information in a visual fashion
116 may not contain any technology. On the other hand, some sophisticated health ID cards (i.e., smart
117 cards) may employ one or more technologies for encoding and storing information. As specified by
118 the INCITS 284 health ID card standard, various technologies may be incorporated in health ID
119 cards, including but not limited to:
120

- 121 • Magnetic stripe
122

123 The magnetic stripe is a relatively simple and inexpensive older technology having been used in
124 the banking industry for decades and for various other common applications including driver's

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125 licenses, subway passes and building access cards. Magnetic stripes can contain a number of
126 tracks; tracks 1 and 2 are utilized for financial transactions, while track 3 remains largely unused.
127 Track 3 can store 82 characters which is sufficient capacity for essential healthcare identification
128 information². The ubiquity of magnetic stripe readers in providers' offices and the ability to
129 combine banking and healthcare information in a single machine-readable ID card, such as can
130 be used for health savings accounts, makes this technology appealing to health plans. In fact,
131 some health plans (e.g., Humana) currently issue combined medical/bank cards utilizing
132 magnetic stripe technology. In general, health plans do distribute and utilize magnetic stripe
133 enabled ID cards to varying degrees, often limiting issuance to certain plans, networks, or
134 geographic areas.

135
136 • PDF417 2-dimensional bar code

137
138 PDF417 2-dimensional bar code is a newer technology that is used in a variety of applications
139 including transport (airline boarding passes), identification cards and inventory management. It
140 has a much greater capacity for storing information than the magnetic stripe. A single PDF417
141 symbol can theoretically hold up to 1850 alphanumeric characters; actual capacity can vary
142 depending on several factors (e.g., area dimensions, printer resolution).

143
144 In the years before HIPAA, the pharmacy industry developed its own means of plan
145 identification and the routing of claims through a national network. This process is dependent
146 upon several additional identifiers unique to the pharmacy industry (RxBIN, RxPCN, RxGroup)
147 in order to process the transactions. The additional requirement for pharmacy identifiers
148 combined with the data storage limitation of the magnetic stripe has guided the pharmacy
149 industry to embrace PDF417 technology in the *Health Care Identification Card – Pharmacy
150 and/or Combination ID Card Implementation Guide (Version 2.0)*. It is important to point out
151 that while the pharmacy industry recognizes the operational efficiencies that can be created by
152 automated card reading and has specified use of PDF417 bar codes, pharmacy workflow at the
153 point of service remains primarily data entry driven.

154
155 • Contactless integrated circuits and integrated circuits with contacts

156
157 Generally referred to as a “smart card”, these technologies have a much greater capacity to store
158 information than either magnetic stripe or PDF417 bar code. These technologies have the ability
159 to transfer and process data without touching the reader (contactless) via radio-frequency
160 identification (RFID), or through physical contact with an electrical connector. Smart card
161 technology is often deployed by large healthcare providers in order to streamline the registration
162 process (e.g., hospital admissions or repeat services) and store some clinical patient information,
163 though the cost is considered prohibitive for typical small group practice implementation.

164
165 The WEDI IG requires that a card include either magnetic stripe track 3 and/or PDF417 2-
166 dimensional bar code machine-readable technology. It does not preclude the card issuer from
167 including additional technology. A difference in application of technologies across various sectors
168 of the healthcare industry, as noted, does present certain challenges in moving toward a single
169 technology. The industry's willingness to move toward adoption of a single technology first

² As defined by the WEDI IG, essential information consists of (1) Subscriber or Member Name, (2) Subscriber or Member ID, and (3) Standard Health Plan ID.

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170 assumes general agreement that the benefits of implementing any technology at this time outweigh
171 the associated costs. In theory, consensus on a single technology must also have taken cost into
172 consideration as one of the factors in determining a most suitable single technology for the majority
173 of stakeholders. These factors must be considered by card issuers, providers, and vendors alike. The
174 Phase III Health ID Card Subgroup will explore these and other factors should it pursue the
175 possibility of further constraining the options for health ID card technology.
176

177 **2. Non-Uniform Physical Characteristics, Data Content, Data Content Format and Layout**
178

179 Without current industry consensus/agreement on following standard specifications for content or
180 appearance and over 100 million health ID cards in circulation, there is considerable variation in the
181 ID cards seen by healthcare providers. This variation ultimately results in the provider or provider
182 office staff spending more time and effort to find the necessary information on the patient's ID card.
183 Other difficulties brought about by non-uniform appearance of health ID cards include, but are not
184 limited to:

- 185 • Pertinent information may not always be included (e.g., provider services contact
186 information)
- 187 • Printed information may not be clear due to labeling, abbreviations, or inconsistent
188 nomenclature
- 189 • Printed information may be difficult to read due to font, font size or color
- 190 • Appearance of information on the card may be cluttered and/or not lend itself for clear
191 photocopying
- 192 • Tearing, creasing, delaminating and other varying degrees of disintegration
- 193 • Health service professional offices must spend time to educate staff in order to "read" ID
194 cards
195

196 While the WEDI IG establishes a basis for uniform implementation of a health ID card, the card
197 issuer is afforded considerable discretion. The physical characteristics of the card (e.g., dimensions,
198 bending stiffness, durability) and recording techniques (e.g., embossing of characters, magnetic strip
199 encoding technique) are well specified in INCITS 284 by reference to other standards including ISO
200 7810 and 7811. However, other than the general format and placement of required "essential"
201 information (i.e., cardholder name, cardholder identifier, card issuer identifier, machine-readable
202 stripe or image), there is broad tolerance of data content specifications. The significant latitude
203 given to employing discretionary or "optional" data and data placement may limit the degree to
204 which uniformity is achieved and thereby reduce the benefits of a WEDI IG-compliant ID card.
205

206 The CORE Phase III ID Card Subgroup may need to consider further constraining the WEDI IG data
207 element specifications, both required and discretionary fields and formats, in order to achieve greater
208 uniformity and functionality of standard machine-readable ID cards. Furthermore, the content of
209 any particular data field may not always be populated by the card issuer so that a patient can be
210 positively matched. While counter intuitive, this situation may occur when, for example, the names
211 in a database utilized for printing ID cards may vary from those in the claims processing or
212 eligibility database. This may be an additional consideration for the Subgroup when reviewing ID
213 card data content specifications. Refer to below table from the WEDI IG specifying required,
214 situational, and discretionary printed information (required fields highlighted in bold italics):
215

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Information Element	Label*	Information Element	Location
<i>Machine-readable strip or image</i>	<i>na</i>	<i>Required</i>	<i>§12.0, 13.0 Front and/or Back</i>
<i>Card issuer name or logo; additional information at issuer discretion</i>	<i>As needed</i>	<i>Required</i>	<i>Front Side</i>
<i>Card issuer identifier; PlanID (c.f. §3.4)</i>	<i>Standard label required; see §3.4</i>	<i>Required</i>	<i>Front Side</i>
<i>Cardholder identifier, a unique identifier assigned by the card issuer. (c.f. §3.3)</i>	<i>Label required, such as: “Subscriber ID” “Member ID”</i>	<i>Required</i>	<i>Front Side</i>
<i>Cardholder name. Name shall correspond to cardholder identifier. Cardholder is subscriber, member, patient; cardholder may be a dependent (c.f. §3.2 and 5.2(1)).</i>	<i>Label such as: “Subscriber” or “Member” Label is Discretionary</i>	<i>Required</i>	<i>Front Side</i>
Dependent name when card issued to a dependent but dependent is not cardholder. (c.f. §5.2(2))	Label indicating dependent/s is required	Situational, required if card is for dependent who is not cardholder	Front Side
Employer or Group Health Plan name	As needed	Recommended	Front Side
Proprietary Policy Number, Group Number, or Account. (c.f. §5.3)	Label required if data present	Situational, Required when differs from card issuer ID and payer needs it	Front Side
<i>Type, purpose, and supplemental benefits; for example, HMO, POS, EPO, PPO, and Drug, Vision, Dental.</i>	<i>As needed</i>	<i>Required but may be implicit from plan or network logos</i>	<i>Front Side</i>
<i>Medicare Part-D Logo, CMS contract number, Pharmacy Benefit Package number</i>	<i>As specified by Medicare Part-D</i>	<i>Situational, Required if Medicare Part-D</i>	<i>Front Side</i>
<i>Name(s) and address(es) such as claims submission address.</i>	<i>As needed</i>	<i>At Least One Address Required</i>	<i>Recommend Back Side</i>
<i>Contact telephone number(s) for benefit eligibility inquiry, patient assistance, claim inquiry, pre-cert.</i>	<i>As needed</i>	<i>At Least One Telephone Number Required</i>	<i>Recommend Back Side</i>
Web site for further information	As needed	Recommended	Either Side
Primary care physician (PCP) name	As needed	Recommended when applicable	Either Side

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Information Element	Label*	Information Element	Location
Primary care physician phone number	As needed	Recommended if PCP included	Either Side
Administrative Services Only (ASO) or Third party administrator (TPA) name/logo.	As needed	Recommended when applicable	Either Side
Provider network name or logo	As needed	Recommended when applicable	Front Side
Annual deductible amount	As needed	Discretionary	Front Side
Co-payment actual dollar amounts: <ul style="list-style-type: none"> • PCP & specialist office visits • Emergency & urgent care 	As needed	Discretionary	Front Side
Co-insurance amount or percentage; explain applicability	As needed	Discretionary	Front Side
Date of birth of cardholder or date of birth of dependent if card issued to dependent	Indication whether cardholder or dependent	Recommended	Front Side
Date card issued	“Card Issued” or “Issued”	Recommended	Front Side
Date card expires	“Card Expires”	Discretionary	Front Side
Date benefits effective	“Benefits Effective”	Discretionary	Front Side
Instructions and contact number for patients with questions.	As needed	Recommended	Back Side
Instructions and contact number for providers with questions.	As needed	Recommended	Back Side
Instructions for hospital admission, prior authorization, pre-certification.	As needed	Recommended	Back Side
Instructions for emergency and urgent care benefits, approval, claim.	As needed	Recommended	Back Side
Instructions for approval of out-of-network benefits and claims	As needed	Recommended	Back Side
Instructions for behavioral health network benefits, approval, claim submission.	As needed	Recommended when applicable	Back Side
Laboratory vendor name or logo and contact information if exclusive	As needed	Recommended when applicable	Back Side
Any other data is permitted	As needed	Discretionary	Either Side

216 * “As needed” means a label is needed if and as judged appropriate by the card issuer to clarify subscriber and
217 provider understanding.
218

219 **3. Non-Standard Health Plan/Payer Identification**
220

221 Improving the automation of healthcare administrative data exchange requires the standardization of
222 certain data elements. HIPAA outlines and includes provisions for designating a uniform and
223 centralized methodology for identifying an employer, provider, health plan and individual in
224 electronic transactions. The current fulfillment status of that provision is shown below:
225

Data Element	Status
Standard Unique Health Care Provider Identifier	Adopted - National Provider Identifier
Standard Unique Identifier for Employers	Adopted - Employer’s Tax ID or Employer Identification Number (EIN)
Standard Unique Health Plan Identifier (i.e., <i>PlanID</i>)	Notice of Proposed Rule Making not yet issued
Standard Unique Identifier for Individuals	Notice of Proposed Rule Making not yet issued

226
227 The primary function of an ID card in the healthcare industry is to provide the information necessary
228 to identify a cardholder and a card issuer in order to conduct various administrative transactions.
229 The individual or card holder is currently identified by a unique number (i.e., subscriber ID or
230 member ID) provided by the card issuer. This number, along with certain demographic information
231 (i.e., first name, last name, date of birth) allows the card holder to be properly identified within the
232 context of the card issuer. If an individual can be identified in this way, than the absence of a unique
233 health plan identifier is the one remaining impediment to achieving unique standard identifiers to be
234 used for health ID cards.
235

236 A standard unique health plan identifier (along with an established publically accessible health plan
237 identifier registry) is critical for creating a means by which a machine-readable health ID card can be
238 used by a provider to efficiently initiate an electronic transaction which can then be “routed” to the
239 appropriate destination. A unique health plan identifier enumeration and registry system is also
240 critical for the industry as a whole by establishing an efficient universal process by which all
241 electronic health care transactions can be “routed” to the appropriate destination. While precisely
242 how such an addressing/routing system might work from a technical standpoint and the exact details
243 for effectuating such an enumeration/registry system is beyond the scope of this particular business
244 case, it must be considered in the context of any potential health ID card CORE rule.
245

246 **Overview of Initiatives Addressing these Issues Today**
247

248 **Private**

249 The healthcare industry has been making strides to address the poor adoption of standard machine-
250 readable ID cards. For example:

- 251 • UnitedHealth Group has begun to issue cards in accordance with the WEDI IG and is
252 planning to distribute nearly 25 million by the end of 2009.
- 253 • Project SwipeIT, an effort led by the Medical Group Management Association (MGMA), is
254 also seeking to advance the adoption of standard machine-readable health ID cards in
255 accordance with the WEDI IG. Project SwipeIT has garnered pledges from health plans to
256 begin issuing standardized ID cards in 2010, pledges from vendors to offer standardized ID
257 card compliant software, and pledges from providers to support standardized ID cards.

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- 258 ○ Humana is an example of a health plan that has pledged to issue ID cards in
259 compliance with the WEDI IG. Non-healthcare stakeholders supporting this effort
260 include U.S. Bank.
- 261 ● As part of its *Health for Life* initiative, the American Hospital Association categorizes
262 reducing administrative costs as part of the framework for healthcare reform. The AHA
263 recognizes that standardizing and improving access to eligibility, enrollment, benefits,
264 coverage and cost sharing information is a vital aspect of reducing administrative costs. To
265 this end, the AHA recognizes that standard machine-readable ID cards can contribute to the
266 process improvement.

267
268 **Public**

269 At a state level, proponents of administrative simplification have also been advocating standard
270 health ID cards as means to reduce healthcare costs and frustrations. In late 2008, an advisory
271 committee formed by Texas legislation to evaluate the use of technology in streamlining the
272 exchange of administrative healthcare information, made a recommendation for health carriers in
273 Texas to issue WEDI IG-compliant standard ID cards. It is anticipated that the Texas legislature will
274 review this recommendation during its 2009 session.

275
276 A Colorado work group, formed by legislation in that state, has also been charged with making
277 recommendations regarding the use of standard health ID cards and other technologies in healthcare.
278 While not specifically mentioned in the legislation, the WEDI IG is under consideration by this
279 group. While no state has formally legislated use of the WEDI IG guide at this time, it is important
280 for the ID Card Subgroup to take into consideration that several states, including Minnesota, have
281 mandated use of the NCPDP IG or substantially similar requirements.

282
283 **Considerations for CORE and ID Cards**

284
285 While setting minimum requirements, the WEDI IG is designed to maximize a card issuer's
286 discretion. As such, this Health ID card IG can serve as the foundation for a CORE rule regarding
287 the implementation of standard health ID cards. As a voluntary standard IG, however, the Phase III
288 Health ID Card Subgroup must first agree to use it as the foundation.

289
290 A Phase III Subgroup of the Rules Work Group will examine how CORE operating (business) rules
291 may be utilized to assist uniform market adoption of standard machine-readable health ID cards for
292 organizations that are issuing such cards and organizations who would be "reading" such cards. Any
293 potential rule regarding voluntary standard ID card requirements must be aligned with CORE
294 Guiding Principles (e.g., promote interoperability, coordinate with other key industry bodies, vendor
295 agnostic). In accordance with CORE's mission, the potential rule will build on existing standards
296 and recognized implementation guides.

297
298 WEDI's IG, the industry approved specifications for implementation of American National
299 Standard, *Identification Cards - Health Care Identification Cards*, INCITS 284, will serve as the
300 foundation for a rule. The WEDI IG was written with significant industry collaboration and
301 approved by the WEDI Board, representing a broad spectrum of industry stakeholders. Therefore,
302 the charge of the Subgroup will not be to revisit every agreed upon WEDI IG specification. Rather,
303 the Subgroup will use CORE's proven consensus based rule writing process to gain agreement on
304 *potential WEDI IG constraints which will help to facilitate more uniform implementation of the*

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305 *standard by card issuers.* This may include, but is not limited to considering WEDI IG-specified
306 recommended or discretionary (i.e., “optional) data elements as required fields. Any potential rule
307 must also be aligned with the NCPDP IG.
308

309 CORE rules apply differently to each of the stakeholder categories for which CORE certification
310 currently exists. Interoperability is an end-to-end process and each stakeholder plays a role. This
311 key principle also applies to the market uptake of machine readable standard ID cards, in so much as
312 benefits cannot be realized by issuance alone. A potential CORE rule might also be used to place
313 requirements upon non-card issuing stakeholders such as providers (e.g., incorporating card reader
314 technology into their work flow) and vendors (e.g., offering software compatible with card reader
315 technology).
316

317 **Assumptions for a Phase III ID Card Rule**
318

- 319 • Utilize the WEDI IG as the ID card rule foundation (if approved by the ID Card Subgroup);
320 any potential CORE rule will also be in-line with the NCPDP IG, since it is complementary
321 and aligned with the WEDI IG.
- 322 • ID card rule will apply to stakeholders implementing standard machine-readable ID cards
323 only; *it is not intended to require organizations* to implement such cards if they have not
324 already done so or do not plan to do so.
- 325 • Any potential Phase III ID card rule will be aligned with the CORE Guiding Principles (e.g.,
326 vendor neutral, coordination with other industry bodies)

Section III: Phase III ID Card Potential Rule Opportunity Areas

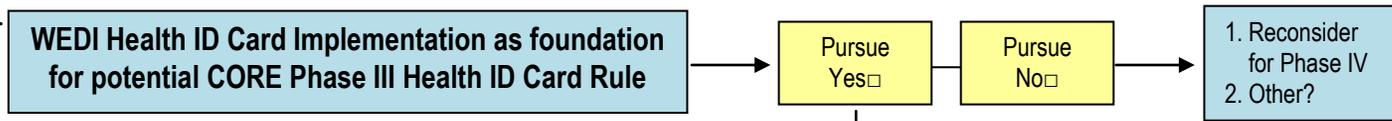
The overarching business justification for implementing a standard health ID card is administrative simplification. In the context of healthcare, this is a broad term used to describe making an administrative process more efficient so as to reduce current costs and frustrations associated with it. As with any standard, implementation guidelines place constraints on the breadth of options for use of the standard in order to establish a more uniform application. Utilizing the WEDI IG as a foundation, the application of a set of CORE rules could address WEDI-compliant implementation of standard machine-readable ID cards in the following ways:

Content-related Constraints

Potential rules that effect the information contained on the card, the layout of content matter, and how the content is formatted. This would include data elements specified as required (i.e., mandatory), recommended or discretionary (i.e., optional) by the standard/WEDI IG or data elements not addressed in the guide. Content-related constraints might also include options for machine-readability.

Infrastructure-related Constraints

Potential rules that pertain to support of private industry issued unique plan identifiers and access/maintenance of related registry systems, requirements for vendors/clearinghouse to support implementation of standard machine-readable IDs, and provider requirements to adopt card reader technology and process workflows.



Phase III ID Card Business Case: Potential Opportunity Areas Identified (in no specific order)						
Content-Related			Infrastructure-Related		Other	
1 – Constrain types of health ID cards for which potential CORE rule requirements will exist (e.g., medical only, combined medical & pharmacy, combined medical and banking, etc) <ul style="list-style-type: none"> Allow for exemptions (e.g., short-term health benefit plans) 	2 – Constrain machine-readable technology format options (e.g., potentially specify a single technology)	3 – Constrain data content and/or content format and/or content layout <ul style="list-style-type: none"> Data Content (e.g., specify a data element not addressed by the WEDI IG to be required, specify a WEDI recommended or discretionary field be required) Content Format (e.g., specify name on card must produce match in card issuer system (eligibility and/or claim) when combined with the individual card issuer's other search/match logic requirements) 	4 – Address standard unique health plan/payer ID issue (e.g. specify a registry and enumeration system or guidelines for establishment of such a system in the absence of a federally sponsored requirement)	5 – Specify card reader technology and/or workflow requirements for providers (e.g., must have the ability to read specified technology format(s), must align patient record name with name recorded by card issuer on ID card)	6 – Specify card reader software integration requirement for vendors (e.g., software must be upgraded to allow for automated capture from card reader)	7 – Specify an implementation timeframe for card issuers and/or other stakeholders (e.g., plans required to comply with ID card rules upon next reissuance of ID cards and vendors upon next version upgrade)
Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>	Pursue Yes <input type="checkbox"/> No <input type="checkbox"/>