Statement To
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
SUBCOMMITTEE ON STANDARDS
Regarding the National Health Plan Identifier

July 19, 2010

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I am John Quinn, CTO of Health Level Seven (HL7) International and on behalf of HL7 I would like to thank you for the opportunity to submit our remarks regarding the upcoming regulations on National Health Plan Identifiers.

HL7 international is the global authority on standards for interoperability of health information technology, with members in over 55 countries and formal affiliates in 35. HL7's vision is to create the best and most widely used standards in healthcare. As an SDO in the US, we collaborate closely with our fellow HIT SDO's and have liaisons to those SDOs as well as other industry organizations as we believe collaboration is extremely important. As we have always engaged others in collaboration, we will also vigorously support that requirement when it comes to National Health Plan Identifiers.

Executive Summary

HL7 has reviewed and in general supports the positions of X12 and WEDI that have been presented here today at this meeting. These position papers were shared with us within the last week or so and we had time to review them. We are making no formal statement about other presentations today either because we did not have an opportunity to review them before this meeting—or because they fall largely outside the scope of the technology behind a National Health Plan Identifier.

HL7's customers are for the most part provider organizations, the HIT vendors that supply those organizations, governments that participate in the support and delivery of healthcare in the US and other countries, and organizations that support any of the areas that I just described (e.g., consultants, manufacturers of IT infrastructure equipment, etc.). Also and please make no mistake about this, *all countries* have health insurance and record and track the delivery of healthcare through mechanisms that closely resemble our use of health plans and health claims. HL7's standards are used to support this activity in many countries with the US being clearly our largest market.

Health Plan information is usually gathered by providers in an IT application at a point of patient contact (e.g., admission, registration, etc.) and then used for claims & billing purposes and communicated to other IT applications both within the source provider organization and external to it. HL7 is almost universally used for the purpose of supporting the provider IT application that collects and first communicates this information. This is true in IT applications that support providers ranging from individual physician practices to very large integrated delivery networks and large government owned and operated health delivery systems. It is possible (or even likely) that a new regulation for Health Plan IDs may require changes to existing provider IT applications which could include screens, work flow and data elements collected, stored, displayed and processed by those applications.

Current Adoption of Health Plan ID information with HL7 in the US

Provider IT applications that collect and use Health Plan information support work flows (i.e., processes) such as visit scheduling, registration, pre-admission, admission, etc. In small ambulatory settings this occurs in a single practice management application that has an included billing component and does not appreciable involve HL7. In any environment that is large enough to include a separate billing and/or financial reporting environment, HL7 is likely to be involved in the communication of patient demographic, charge and payer information to an external billing application and also possibly an external financial reporting system. If these assumptions are accepted then it is safe to assume that we are potentially looking at tens of thousands of existing interfaces that could be impacted by this change.

The adoption and use of these existing HL7 interfaces began to occur as one of the first (if not the very first) set of interfaces that were adopted in the industry going back to HL7's inception in 1987. As a co-founder of HL7 I did work at that time for a vendor organization that was involved in HL7 for specifically these purposes of needing to adopt standard patient demographic and charge capture interfaces. Since this adoption was early in HL7's life and since the adoption was widespread, most, if not all, of these interfaces are based on the family of HL7 Version V2.x (i.e., 2.1-2.6) standards. Please remember that it makes little, if any, financial or technical sense to modify and upgrade an existing working interface to any new revision of 2.x—much less HL7 Version 3—so it is safe to assume that all of these interfaces in the US are HL7 V2.x based.

Here is the layout of the HL7 datatypes that are used to hold an Insurance Plan ID and information when an HL7 V2 message is communicated with insurance and charge information. Not every implementation would necessarily use all of these supported fields.

Components: <ID Number (ST)> ^ <Identifier Check Digit (ST)> ^ <Check Digit Scheme (ID)> ^ <Assigning Authority (HD)> ^ <Identifier Type Code (ID)> ^ <Assigning Facility (HD)> ^ <Effective Date (DT)> ^ <Expiration Date (DT)> ^ <Assigning Jurisdiction (CWE)> ^ <Assigning Agency or Department (CWE)>

Subcomponents for Assigning Authority (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Facility (HD): <Namespace ID (IS)> & <Universal ID (ST)> & <Universal ID Type (ID)>

Subcomponents for Assigning Jurisdiction (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Subcomponents for Assigning Agency or Department (CWE): <Identifier (ST)> & <Text (ST)> & <Name of Coding System (ID)> & <Alternate Identifier (ST)> & <Alternate Text (ST)> & <Name of Alternate Coding System (ID)> & <Coding System Version ID (ST)> & <Alternate Coding System Version ID (ST)> & <Original Text (ST)>

Definition: This field contains unique identifiers for the insurance company. The assigning authority and identifier type code are strongly recommended for all CX data types.

Please note that while text sub-components are supported within the datatype, this construction primarily supports an external coding system identifier(s) where the details of the Health Plan, Guarantor and related benefit plan are contained in an external Codeset database.

It is also important to mention that HL7 has widely adopted the use of ISO Object Identifiers (OIDs) and is a registration body to ISO for OIDs that are created by HL7 itself and its users. An important concept in HL7's use of OIDs for vocabularies and in the use of its standards is that identifiers are best when they have no meaning in themselves. That is, ***All meaning is contained in external databases which can be updated without reissuing identifiers. Of course, the base assumption is that we are using IT systems when we collect and use identifiers…but, after all, is not that what this is all about and not paper?***

Current Adoption of Health Plan ID information with HL7 outside the US

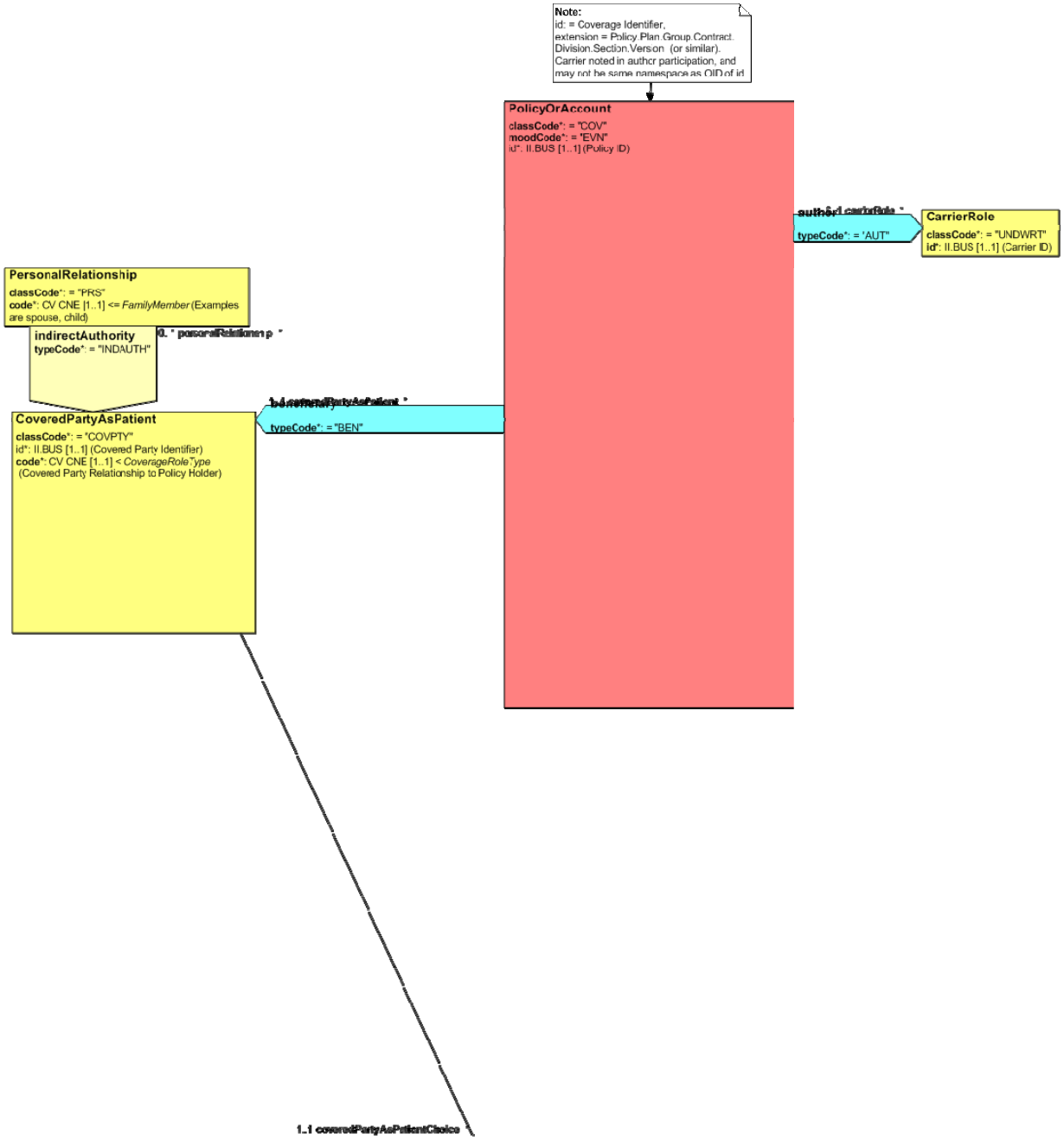
I was also asked to specifically talk to the use of HL7 and Health Plan ID information outside of the US and especially Canada.

Shortly after the HIPAA law was passed in 1996 I, as the chair of the HL7 Technical Steering Committee, was asked to initiate a project in the HL7 Financial Management Chapter (i.e., chap 6 of the 2.x family of standards). Two events had occurred in the previous two years that seemed to make this an unusual request: 1) The HIPAA law seemed to make any HL7 claims transaction impossible since the then recent law specifically named X12, NCPDP and the ADA as the author of those transactions for the US; 2) More than a year before HIPAA was put into law HL7 had, in a spirit of collaboration with X12N, decided to not independently pursue a provider sourced claims transaction that was then sent to payer—X12N and HL7 would collaborate but X12N would produce that standard.

When I gave these reasons for HL7's lack of interest, I was informed that the request was coming from Canada, Australia and New Zealand and that those countries (and later The Netherlands and others) did not use X12 in their countries and wanted claims transactions that were of similar syntax and technology as HL7 which was already widely used within their provider organizations. So HL7 proceeded to develop claims transactions in first HL7 V2.x and later HL7 V3 that are intended for use in HL7 realms outside of the US.

My contact with our Canadian HL7 International Board member, Michael van Kampen has informed me that outside of a few non-standard proprietary implementations, Canada is now using an HL7 V3 claims message. A previous conversation that I had with the chief architect of Canada Health Infoway (Ron Parker) also informed me that he had conducted a recent study and found that X12 is not in use by the Canadian Health System.

I have included a HL7 restricted model from the HL7 Reference Information Model that that shows the datatype (i.e., high-level) Information communicated in a Canadian claims transaction.


Note:
id: = Coverage Identifier,
extension = Policy.Plan.Group.Contract.
Division.Section.Version (or similar).
Carrier noted in author participation, and
may not be same namespace as OID of id
PolicyOrAccount
classCode*: = "COV"
moodCode*: = "EVN"
id*: II.BUS [1..1] (Policy ID)
typeCode*: = 'AUT"
CarrierRole
classCode*: = "UNDWRT"
id*: II.BUS [1..1] (Carrier ID)
PersonalRelationship
classCode*: = "PRS"
code*: CV CNE [1..1] <= FamilyMember (Examples
are spouse, child)
indirectAuthority
typeCode*: = "INDAUTH"
typeCode*: = "BEN"
CoveredPartyAsPatient
classCode*: = "COVPTY"
id*: II.BUS [1..1] (Covered Party Identifier)
code*: CV CNE [1..1] < CoverageRoleType
(Covered Party Relationship to Policy Holder)