NAMIC®

NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

NAMIC is the largest full service property/casualty trade association representing 1,400 member companies writing all lines of property/casualty insurance and accounting for 50 percent of the automobile/homeowners market. Our member companies include small, single-state, regional and national carriers. As the committee considers the application of the standards and operating rules to automobile and workers' compensation insurance, we urge the committee to carefully consider the costly impact on these carriers, particularly smaller insurers.

The Patient Protection and Affordable Care Act ("Act") added new administrative simplification requirements intended to improve the standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act ("HIPAA"). The Act further required the Department of Health and Human Services ("HHS") to solicit input on whether the administrative simplification standards and operating rules should apply to health care transactions of auto insurance, workers' compensation and other programs or persons not currently covered. HIPAA mandated the establishment of standards for financial and administrative transactions to enable the electronic exchange of information for a number of transactions including health care claims, health care payment and remittance advice, and first report of injury. In addition, HHS was required to adopt standards for code sets for each data element for health care transactions, security standards to protect health care information, standards for electronic signatures, and standards for the transmission of data elements needed for the coordination of benefits and sequential processing of claims. HIPAA correctly excluded automobile and workers' compensation claims from compliance with these standards at that time and we believe that remains the correct decision.

First and foremost, we must recognize that property/casualty insurance is fundamentally different from health insurance coverage. The basis for coverage is different, the terminology is different and the insurer's relationship is different. Although we make payments for health care costs as part of both automobile and workers' compensation claims, these payments are but only one component part of a larger claim. Contractual obligation and state law determinations are required to determine whether the claimant, which may be an insured or a third-party claimant, is eligible for coverage, including whether the injuries were the result of a covered event, and whether the claimed medical care qualified for payment. In addition, many claims are adversarial in nature and liability is in question. Furthermore, since property/casualty claims are based on specific covered events, each claim must be identified to a

particular covered event, not just to a specific individual, requiring multiple identifiers. As a result of these and other differences, property/casualty claims would not lend themselves to many of the transaction standards in question, such as eligibility for benefits, first report of injury or even an individual unique health identifier. Forcing "health industry" centric standards and operating rules on these claims would needlessly complicate administration and increase the cost of these claims.

As the committee considers the merits of application to the property/casualty industry we believe it is essential that the cost/benefit of such application be carefully weighed. Automobile and workers' compensation claims represent a small fraction of total health care transactions and the cost of implementation of standards with respect to this small percentage of transactions must be carefully considered. Complying with the new electronic transmission standards and security standards would for most property/casualty insurers require new computer and operating systems, investment in new hardware and software and demand extensive new employee training and claims administration procedures. For smaller companies particularly these costs could be prohibitive. As an example, our companies are still struggling under the new Medicare Secondary Payer Reporting requirements. They have invested significant financial resources and human capital in developing, implementing, testing and training for new data capture and reporting systems and yet the program continues to undergo modifications and it is unclear, and we believe unlikely, that the benefit to the federal government will outweigh the cost to the companies. Similarly, we note that even previously covered entities which have been complying with HIPAA administrative simplification and electronic data transmission standards for a decade are still struggling under the weight of new requirements. As an example, the decision by HHS yesterday to delay enforcement of the requirement to use the ASC X12 Version 5010 standards acknowledged that a majority of covered entities would be unable to be in compliance by January 1.

Application of the standards to property/casualty insurers would impose significant burdens on companies in an unsettled world, one in which technology is moving rapidly and standards are changing. To ask property/casualty companies to make such a financial investment in the absence of any documented significant benefit during a period of such rapid change is imprudent and we urge the committee not to make such a recommendation at this time.

National Association of Mutual Insurance Companies
122 C Street, NW, Suite 450
Washington, D.C. 20001
202-628-1558
www.namic.org