National Committee on Vital and Health Statistics
Subcommittee on Standards
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TESTIMONY BY THE AMERICAN MEDICAL ASSOCIATION
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The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics' (NCVHS) Standards Subcommittee (Subcommittee) for the opportunity to provide our proposal on the National Health Plan Identifier (NHPI). The adoption of an NHPI provides an invaluable opportunity to eliminate the ambiguity that makes health care transactions so costly today. This ambiguity stems from the fact that the term "health plan" can mean a host of different things, ranging from the specific health insurance product an individual buys to the national company that sells that product, including each of the intermediaries involved in the multitude of transactions which occur when administering our third-party payment system.

The increasing complexity of health plan transactions is staggering. In the early 1990s, identification of the health plan was fairly simple and straightforward. The ultimate payer, generally an employer or a pension and welfare fund, contracted with a health insurer to either provide a fully insured HMO or PPO plan to its employees, or to at least handle the provider network services and administrative functions associated with its self-insured plan.

Today, there are numerous entities serving in health plan roles, and many of these entities provide a variety of services, some overlapping with other entities. Even national health insurers subcontract with various "carved out" benefit management companies, such as pharmacy benefit managers (PBMs) and behavioral health benefit managers, and with preferred provider networks (PPNs) to augment their directly contracted networks. Self-insured benefit plans similarly utilize a plethora of different entities to handle various administrative functions. And, the traditional PPO/HMO benefit plan models have been replaced by a wide variety of different benefit structures, each with different administrative and patient financial requirements.

A complete health plan enumeration system, coupled with the upcoming implementation of the Accredited Standards Committee X12 005010 electronic transaction standards, will finally make it possible to make sense out of the current chaos, and enable the automation of our third-party payment system. By clearly enumerating each of the discrete attributes of the complex third-party payment process, computers will finally be able to process transactions that currently require human intervention.

A robust NHPI system could eliminate the confusion that arises today from the following factors:

> **Ambiguity tied to the proliferation of administrative intermediaries.** It is common for a self-insured employer's health benefit plan to contract with a health insurer to perform administrative services that the health benefit plan would otherwise perform itself. That health insurer, in turn, very often subcontracts administrative services to other "intermediary" entities, such as PBMs, mental health benefit managers, radiology benefit managers, PPNs and/or fee negotiation

companies to perform various administrative functions that would otherwise be undertaken by the health insurer in its administrator role.

Ambiguity arising from multiple provider contracts. For example, the average physician practice contracts with 12 different health insurers simultaneously. Each of these contracts, in turn, requires the physician to participate in up to 5 different products. And each of these products may be tied to a different fee schedule. To add an additional level of ambiguity, many health care providers also contract with PPNs, which in turn "rent" their networks to self-insured employers or health insurers, or even other PPNs. As a result, health care providers who assume they are "out-of-network" with respect to a patient who presents an ID card with the name of a health insurer with which they do not contract may, in fact, be "in-network" as a result of a contract with a PPN that has been rented to that health insurer.

Ambiguity stemming from numerous benefit plan designs. There are hundreds—if not thousands—of patient-specific benefit plans today. Each of these benefit plans imposes a different set of requirements for physicians and other health care providers to learn and negotiate. There are different copayment, co-insurance and deductible requirements, some of which may vary based on the services that are rendered and/or the referral source. There are also widely varying prior authorization and other rules. There are even different processes for resolving disputes.

Ambiguity resulting from ERISA preemption. Different rules apply to health benefit plans that are subject to state insurance laws and those that, because they are sponsored by self-insured employers, are not.

Ambiguity resulting from the widespread lack of transparency. To efficiently manage a patient's care, a health care provider must know all of the following:

Information Needed	Rationale
The identity of the insurance product/benefit plan in force for the specific patient.	This information is necessary to determine the patient's benefits, deductible amount, copayment and co-insurance percentage, prior authorization requirements, and the patient's in- or out-of-network status. Moreover, it is not enough to merely identify the product type. For example, the fact that a standard transaction identifies that a patient has a PPO plan is not specific enough to identify which PPO plan. Many payers offer numerous PPO products (e.g., PPO Gold Benefit Plan, PPO Silver Benefit Plan or Medicare Advantage Gold PPO Benefit Plan), each with varying benefit levels, patient financial benefit levels, prior authorization requirements, and other contractual requirements.
The identity of the entity that will initially receive the transaction.	This is needed to expedite proper routing of the transaction
The identity of the entity responsible for administering the health care transaction.	This information is needed to enable resolution of any issues concerning the transaction.
Identify the entity that will fund the claim payment (not payment of the premium).	Clearly identifying when a patient's benefit plan is funded by a self-funded employer assists the physician and patient in understanding what the legal obligation and ramifications are for the provision of the patient's medical care. Many physician contracts establish different rules for insured versus self-funded claims, and many state departments of insurance will only assist with issues concerning insured claims. Patients also need to know who holds the fiduciary responsibility to determine medical necessity and benefit coverage.

The identity of the entity that contracts directly with the health care provider.	This is needed to establish which contract is in force for the claim. Often times, there may not be any direct relationship between the contracted fee schedule and the patient's specific benefit plan.
The identification of the fee schedule that applies to the claim.	This information is necessary to access the fee schedule applicable to the claim from the contracting entity to predict the patient's financial responsibility prior to or at the time of service and also to enable the physician or other health care provider's practice management system to automatically reconcile and post the claim payment. This is simply an identifier to access the fee schedule, not the fee schedule itself nor the pricing and payment rules that are to be applied to a specific claim.

However, it is rare that all this information is included in the electronic transactions today. Indeed, there is no way that the current "payer ID" used as the routing address can communicate all this information.

The current lack of clear identification of each of these attributes adds enormous cost to the health care system, as all parties are forced to resolve these ambiguities with manual processes, including telephone calls, faxes, letters, e-mails and appeals. The single routing "payer ID" typically used today cannot provide the necessary information in most cases. There are billions of dollars of cost savings associated with a robust health plan identifier system that does more than just identify where health plan transactions should be routed.

RECOMMENDATION

Based on our investigation and discussions with participants throughout the system over the last three years, we recommend an NHPI that clearly identifies: (1) the patient's specific benefit plan (NHPI Type 1) and (2) each organization that performs a health plan function in the health care electronic standard transactions (NHPI Type 2).

Type 1 NHPI: Patient-specific benefit package
Products could include: Health insurance product, employee benefit plan or other product defining the patient's coverage.
Recommendation: Each separate benefit package would have a separate Type 1 NHPI.

We understand that there are a large number of group health plans. We believe further investigation is necessary to determine whether it is necessary to separately enumerate the patient-specific benefit plans that are offered by each of those group health plans that have purchased health insurance, or whether it is enough to simply enumerate the specific benefit plans that are purchased by these group health plans from health insurers. From the provider perspective, the identity of the employer that paid the health insurance premiums on behalf of a patient who is covered by a fully insured plan is generally unnecessary. On the other hand, "group numbers" identifying these employer-purchased health insurance benefit plans are available today.

Type 2 Entity NHPI: Each entity that performs a health plan function
Entities to receive an NHPI would include:

1) entities that have responsibility for ***receiving*** standard transactions (e.g., the primary, secondary or tertiary payer; third-party administrator; network pre-pricer or repricer; employer; PBM or other outsourced benefit manager);

2) entities that have responsibility for ***administering*** standard transactions (e.g., the health insurer, PBM or other out-sourced benefit manager, third-party administrator);

3) entities that have responsibility for ***contracting*** directly with health care providers (e.g., the health insurer, PPN, fee negotiation company); and

4) entities that have responsibility for ***funding*** of the benefit (not payment of the premium) (e.g., self-insured employer, health insurer, government payer).

Each of these entities would receive only one identifier. If an entity plays more than one role in any given transaction, that will be indicated by placement of the NHPI in the appropriate fields in the standard transaction.

Finally, to enable full automation of the eligibility (X12 270-271) and claim (X12 837-835) standard transactions, entities that have responsibility for ***contracting*** directly with health care providers must also disclose which of the health care provider's contracted fee schedules will apply to the services to be provided to a particular patient by disclosing on the eligibility response (X12 271) and remittance advice (X12 835) standard transactions an identifier for the specific fee schedule applicable to the transaction. The AMA recommends this be done with a fee schedule identifier following a national standard format, generated by the entity that contracts directly with the health care provider. To be clear, the fee schedule identifier is just an identifier that enables the health care provider to load the appropriate fee schedule, just as the entity that is administering the claims transaction must do to price the claim. The AMA is not proposing that the fee schedules themselves be made public.

With respect to the types of entities that would be required to obtain a Type 2 NHPI, the AMA proposal adopts an approach very similar to that taken by the Centers for Medicare & Medicaid Services (CMS) in the National Provider Identifier (NPI) final rule. In that rule, CMS *required* covered health care provider organizations (e.g., hospitals) to obtain Type 2 NPIs for organizational components that themselves were legally separate covered health care providers, even though the health care organization was already required to have an NPI. See 69 F.R. page 3438. For example, an ambulatory surgery center (ASC) that is a separate legal entity from a hospital must obtain its own NPI if it is a covered health care provider, even if the ASC is a component of that hospital. However, CMS did not *require, but merely permitted,* covered health care provider organizations to obtain NPIs for so-called "subparts." In contrast to component-covered health care providers that are legally distinct from their overarching organizations, subparts are *not* separate legal entities from their larger covered health care provider organizations. For example, a psychiatric unit that is not a legal entity distinct from its hospital would constitute a "subpart" of that hospital under the NPI final rule. The NPI final rule would not, therefore, require the hospital to obtain a separate NPI for that unit. The hospital may, however, obtain an NPI for its psychiatric unit if the hospital would so choose. Id.

Similarly, under the AMA proposal, organizations performing health plan functions would not be required to obtain a Type 2 NHPI for any of their divisions, units or programs that are not separate legal entities, but they would be permitted to do so if the entity wished to do so for business reasons. For example, a health insurer administering claims processing functions utilizing various processing platforms would not be required to obtain NHPIs for each of those platforms, so long as those platforms were not legal entities distinct from the health insurer. But the health insurer would be permitted to obtain NHPIs for each of those platforms if, for example, the health insurer preferred to have claims routed directly to those claims platforms. The AMA proposal would, however, require all legally distinct entities involved in performing health plan functions to obtain their own NHPIs.

The following chart demonstrates the similarity between the AMA NHPI proposal and the NPI final rule.

National Provider Identifier (NPI), Definitions from the NPI Final Rule	**National Health Plan Identifier (NHPI) Proposal**
NPI Type 1: Individuals who render health care (e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists and sole providers). **NPI Entity Type 2**: Organizations that render health care services, or furnish health care supplies to patients (e.g., hospitals, home health agencies, ambulance companies, health maintenance organizations, durable medical equipment suppliers, pharmacies and corporations formed when an individual incorporates). An organization can enumerate a subpart. A subpart is a component of an organization health care provider. A subpart may be a different location or may furnish a different type of health care than the organization health care provider. For ease of reference, we refer to that organization health care provider as the "parent."	**NHPI Type 1**: Patient-specific benefit plan (patient-specific benefit package) (e.g., health insurance product, employee benefit plan or other product defining the patient's coverage, including the patient's financial responsibility and all administrative requirements). **NHPI Entity Type 2**: Organizations that perform health plan functions (a "payer" role) in the health care electronic standard transactions. These include: 1) The entity responsible for receiving each transaction (e.g., the routing code for each of the following: primary, secondary or tertiary payer, third-party administrator, network pre-pricer or repricer); 2) the entity responsible for administering each transaction (e.g., the health insurer, PBM or other out-sourced benefit manager, third-party administrator); 3) the entity that contracts directly with the health care provider (e.g., health insurer, rental network); and 4) the entity with the responsibility for funding the benefit (not payment of the premium) (e.g., health insurer, government payer). An organization can enumerate a subpart. A subpart is a component of an organization that performs health plan functions. A subpart may be a different location or may furnish a different type of health plan function. For ease of reference, we refer to that organization health care provider as the "parent." [1] This entity must generate an identifier for each contracted fee schedule (i.e., the complete list of contract rates before the application of pricing rules) following a national standard format. This identifier must be placed on each relevant transaction, such that the health care provider can access the contracted fee schedule applicable to each transaction from the entity.

Similar to the NPI, which enumerated physicians and other health care providers both as individual professionals and as organizations, this proposal breaks down the complex third-party payment process into its discrete attributes and allows for enumeration of each of those attributes. This will enable the NHPI to be used not just to route electronic transactions but also to identify each relevant entity and patient-specific benefit plan each time they are relevant to a specific electronic transaction between the trading partners.

COMPOSITION

The AMA proposal does not take a position on the composition of the NHPI. This could be a number with or without intelligence and/or could continue the use of existing identifiers.

IMPLEMENTATION

We envision a fully automated process for health care transactions. We contend that NHPIs can be used with other standard identifiers within the 5010 Version of the X12 health care standard transactions to facilitate automated transactions and claims adjudication processes. To illustrate the concept, we will

use the X-12 270/-271 eligibility request and response as an example. The following representative examples are intended to demonstrate possible solutions; the final requirements would need to be adopted by the appropriate standard setting bodies.

Implementation Scenario One

Let's start with a very simple transaction, in which an employer contracts with a health insurer to provide a single fully-insured plan for its employees that is entirely administered by the health insurer, which also has the direct contract with the physician who has provided services.

Step One: Patient schedules an appointment either in person, by phone or on a physician's website.

The physician submits an X12 270 eligibility request standard transaction to the claims administrator or other entity identified on the patient's health insurance card supplied by the patient or other automated process when the patient's health insurance card is not presented or does not contain the appropriate routing address.

Step Two: The physician receives an X12 271 eligibility response in which the single NHPI (Type 2) for the health insurer would appear in each field in the transaction, denoting each of the four roles it is performing: (1) claim routing entity, (2) funder of benefit, (3) claims administrator, and (4) physician contract holder. In addition, the health insurer would provide the NHPI (Type 1) of the patient's specific benefit plan, and, associated with its role as the contracting entity, the health insurer would provide the identifier necessary to access the fee schedule applicable to the claim.

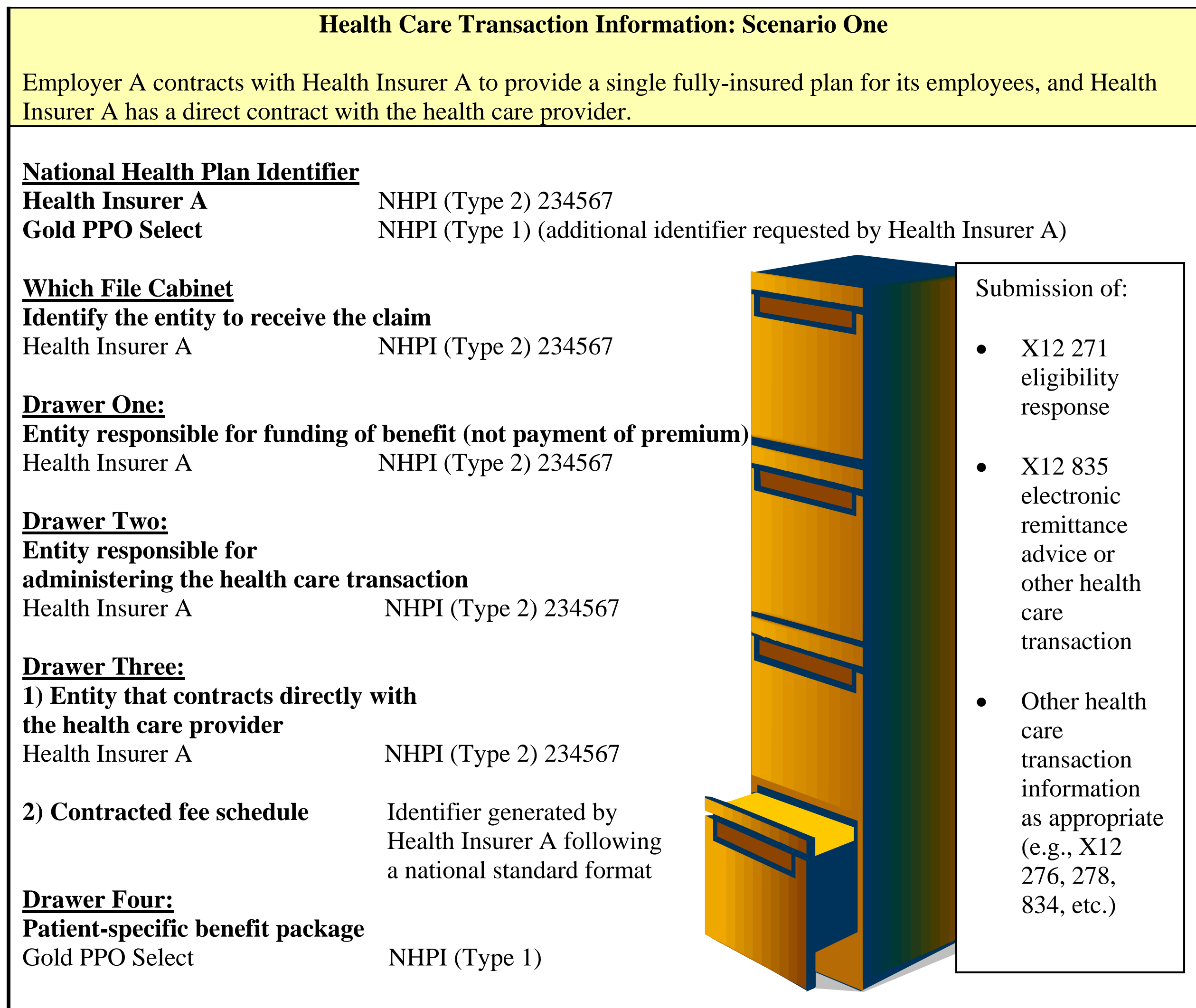
HIPAA 5010 Version X12 271 eligibility response standard transaction
Receive on the X12 271 eligibility response standard transaction the NHPI of entity responsible for receiving the claim, NHPI of entity that serves as the claim administrator, NHPI of the entity that holds the contract with the physician or other health care provider, and the NHPI (or National Employer Identifier (NEIN), if employer) of the entity responsible for funding the benefit. In conjunction with these identification numbers, associated identifying information required for final claim adjudication should be incorporated, including a fee schedule key (identifier) and product/plan identifier. Possible locations on the 005010x279 271 for required information: ▪ Claim routing entity: Loop 2120C NM101 = PRP, NM108 = XV (NHPI) *(also can be found on Member ID card)* ▪ Claim Administrator: Loop 2120C NM101 =PR, NM108 = XV (NHPI) ▪ Product/Plan: Loop 2110C EB05 = Plan name or product name ▪ Contract Responsibility: Loop 2100C REF01 =CT, REF02 = NHPI • Key to Fee Schedule: Loop 2100C REF01=CT, REF02 =possibly require fee schedule number embedded in Contract Number ▪ Funding Responsibility: Loop 2120C NM101=P5, NM108 = XV (NHPI) or 24 (EIN) Note: All usages of NHPI should be supported by standard usage rules and incorporated into future transactions from X12 and other SDOs to prevent confusion. Additional illustrations are provided in Appendix A

Each entity may receive one or more NHPI (Type 2) numbers, depending on the subparts it chooses to enumerate, as needed for routing and identification purposes. The NHPI (Type 2) can be used in any transaction in which it is referenced in the existing Technical Report Type 3 (TR3) to define any of the roles identified in the transaction. Thus, in transactions in which a health insurer performs multiple functions, that health insurer's NHPI (Type 2) would appear in each appropriate field, while in transactions in which the responsibilities have been dispersed, there could be several different NHPIs involved, each included in a field specific to that role.

In addition, when more than one entity serves in the same role, more than one NHPI (Type 2) could theoretically be reported on a single X12 271 transaction. For instance, when a mental health benefit has been carved out from a patient's specific benefit plan, there could an NHPI (Type 2) for the behavioral health carrier separate from the NHPI (Type 2) of the health insurer, thus allowing routing of mental health claims separately from claims for other health care services. While there needs to be a national standard created for the fee schedule identifier, the identifier itself should be generated by the entity that directly contracts with the physician or other health care provider.

With this information, the physician knows where to submit the claim, what the specific benefit plan is for the patient, whether the patient is in- or out-of-network, if the claim is self funded by the employer or fully funded by a health insurer, allowing the physician to know whether this visit is subject to the general or commercial agreement to ensure prior authorization and other requirements and determine what fee-schedule will apply.

To look at this transaction from another perspective, let's explore a file cabinet analogy, in which the routing number would bring you to the correct file cabinet and each drawer represents a loop in the 5010 eligibility response transaction that we just discussed.



Health Care Transaction Information: Scenario One

Employer A contracts with Health Insurer A to provide a single fully-insured plan for its employees, and Health Insurer A has a direct contract with the health care provider.

<u>National Health Plan Identifier</u>

Health Insurer A	NHPI (Type 2) 234567
Gold PPO Select	NHPI (Type 1) (additional identifier requested by Health Insurer A)

<u>Which File Cabinet</u>
Identify the entity to receive the claim
Health Insurer A — NHPI (Type 2) 234567

<u>Drawer One:</u>
Entity responsible for funding of benefit (not payment of premium)
Health Insurer A — NHPI (Type 2) 234567

<u>Drawer Two:</u>
Entity responsible for administering the health care transaction
Health Insurer A — NHPI (Type 2) 234567

<u>Drawer Three:</u>
1) Entity that contracts directly with the health care provider
Health Insurer A — NHPI (Type 2) 234567

2) Contracted fee schedule — Identifier generated by Health Insurer A following a national standard format

<u>Drawer Four:</u>
Patient-specific benefit package
Gold PPO Select — NHPI (Type 1)

Submission of:

- X12 271 eligibility response
- X12 835 electronic remittance advice or other health care transaction
- Other health care transaction information as appropriate (e.g., X12 276, 278, 834, etc.)

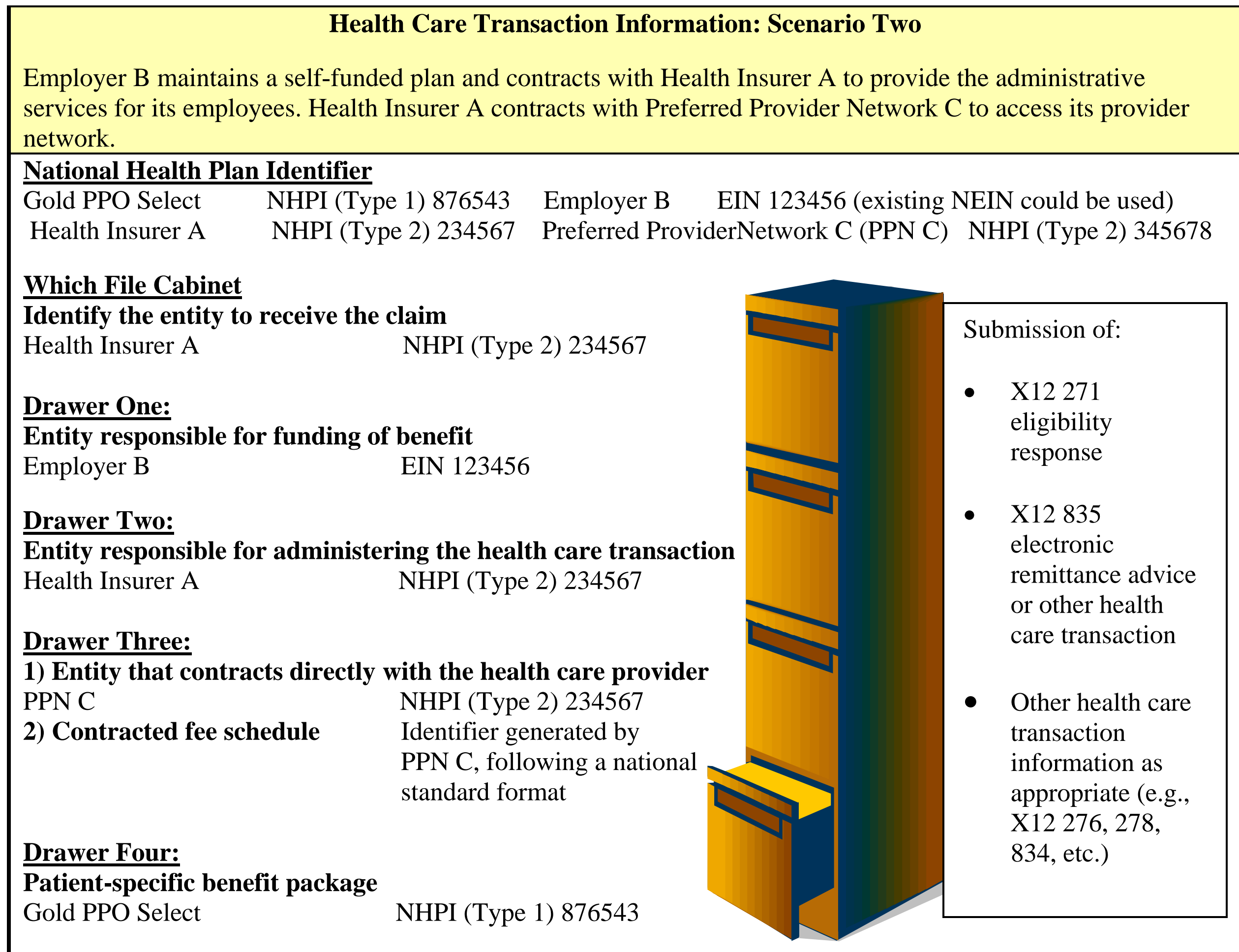
Implementation Scenario Two

Now let's go through a more typical transaction in which an employer maintains a self-funded plan and subcontracts with a health insurer to provide the administrative services for its employees. In turn, the health insurer subcontracts with a PPN that has the direct contract with the physician who has provided services.

Step One: Patient schedules an appointment.

The physician submits an X12 270 eligibility request standard transaction based on the information provided on the patient's health insurer identification card, or as otherwise supplied by the patient.

Step Two: The physician receives the X12 271 eligibility response, in which the NHPI (Type 2) for each of the entities involved would appear in the field in the transaction, denoting the role that entity was performing: (1) The health insurer NHPI (Type 2) would be indicated for the claim routing entity; (2) the employer NHPI (Type 2) (or NEIN) would appear in the field for the funder of the benefit; (3) the health insurer NHPI (Type 2) would again appear in the field for the claims administrator; (4) the PPN's NHPI (Type 2) would appear in the field for the entity holding the direct contract with the physician (in addition, the PPN would forward the identifier necessary for the physician to access the fee schedule applicable to the claim in a national standardized format); and (5) the patient-specific benefit plan (Type 1).



Clear identification of each of these entities' NHPI (Type 2), patient-specific benefit plan NHPI (Type 1) and specific fee schedule identifier is necessary for full automation of electronic health care transactions.

The information received on the X12 271 transaction is then loaded into the health care provider's practice management system. This significantly reduces costs to the health care system, as all parties are able to reduce the manual intervention required when ambiguities remain.

Claim and Payment Process

Submission of an X12 837 professional claim is sent to the entity that will receive the claim, based on the patient's health insurer identification card or contained on the X12 271 eligibility response, when the information is made available to the physician or other health care provider.

Possible location on the 005010x222 837 for required information:

- Entity to receive the claim: Loop 2010BB—NM101=PR, NM108=XV (NHPI Type 2)

Receive on X12 835 electronic remittance advice the NHPI (Type 2) of entity that served as the claim administrator, the NHPI (Type 2) of the entity that holds the contract with the physician or other health care provider, and the NHPI (Type 2) (or NEI, if employer) of the entity responsible for funding the benefit. In conjunction with these NHPIs, associated identifying information required for final claim adjudication should be incorporated, including a fee schedule key (identifier) and product/plan identifier.

Possible locations on the 005010x221 835 for required information:

- Claim Administrator: Loop 1000A NM103
- Product/Plan: Loop 2100 REF02
- Contract Responsibility: Loop BPR?
    - Key to Fee Schedule: Loop 2100 REF02?
- Funding Responsibility: BPR11, TRN04

Note: These loops are not currently all designed for the information specified. This is an illustration of the type of usage that X12 and any Usage Rules entity would need to create rules to effectively utilize the NHPI for these functions. Additional illustrations are provided in Appendix A.

<u>CONCLUSION</u>

Learning from the past

Transition phase

It will be important to carefully consider how best to handle running systems using any health plan, clearinghouse or practice management system existing legacy numbers with the NHPI, as running dual identification numbers became quite cumbersome during the transition to the NPI despite the fact that it allowed for interim steps to implementation. CMS is strongly encouraged to work closely with all the key stakeholders to ensure feedback is sought at key junctures along the way to NHPI implementation. Key stakeholders should also be encouraged to assist CMS with the critical outreach that will be required to ensure sufficient awareness that will lead to the successful implementation of NHPIs.

Infrastructure and required modifications

A number of lessons were learned during the NPI enumeration process that should be taken into consideration as plans for NHPI implementation continue:

- Every effort must be made to ensure physician and other health care provider payment interruptions are averted. Specifically, clear and flexible guidance must be created and shared widely on opportunities to receive advance payments (the problems experienced during the NPI transition need to be eliminated).

- Clear messaging from CMS and all its contractors is needed in order to ensure a smooth transition.

- CMS should work closely with all HIPAA-covered entities and the vendor community to ensure feedback is sought at key junctures of the implementation process and on critical outreach.

- Education on interim steps necessary to implementation will be helpful.

- Running dual identification numbers, NHPI and legacy numbers, could be cumbersome and inefficient for physicians and other health care providers, yet they may become necessary to facilitate a smooth transition.

Benefits

The transparency of payment and administrative responsibility created as a result of a fully enumerated third-party payment system will enable each party of the health care system to benefit as follows:

Patients
- More fully understand what a medical visit or service will cost them, thus allowing them to understand whether their in- or out-of-network deductible is applicable and to take a more active role in their selection of health care professionals and medical services
- Reduce the number of calls, appeals and other disputes
- Pay the amount they owe at the time of service rather than waiting for a bill that won't come for many weeks

Employers and Government Payers
- Increase their employees' or subscribers' understanding of health care costs
- Save money through increased accuracy of payment reconciliation and reduced calls, claim appeals, and other manual efforts to identify the party necessary to resolve the dispute

Health Insurers
- Increase their subscribers' understanding of health care costs
- Save money through increased accuracy of payment reconciliation and reduced calls, claim appeals, and other manual efforts to identify the party necessary to resolve the dispute
- Increase trust with physicians and other health care providers through increased first-pass automated claims reconciliation

Third-Party Administrators and Administrative Services Organizations
- Save money by increasing first-pass payment accuracy and reducing the number of contracts and claim appeals

Provider Networks

- Increase accuracy of contract administration and claims repricing
- Identify misapplication of contracted discounts by other entities
- Increase the willingness of physicians and other health care providers to contract with the provider network by reducing skepticism that contractual discounts will be abused by those who are not entitled to them

Physicians and other health care providers and their agents, such as practice management system vendors, billing services and clearinghouses

- Enhance relationships with their patients by eliminating financial or other surprises as a result of knowing upfront: (1) whether they are in- or out-of-network, and if in-network, the entity with which they have a direct contractual relationship and the specific fee schedule that will apply to the services they provide to each patient; (2) whether there is an outsourced benefit manager; and (3) the patient's financial responsibility (remaining deductible and copayment or co-insurance amount)
- Save money by reducing the need for manual processes to obtain this necessary information and by increasing the number of claims that are automatically reconciled and posted, without the need for manual intervention or appeal

Summary

Given the complexity of the third-party payment process, only robust health plan identification requirements can achieve the types of efficiencies and significant cost savings to the health care system that Congress intended to achieve when it mandated the promulgation of national identifiers and standard health care transactions. Only when physicians and other health care providers receive complete, accurate and transparent information concerning all relevant aspects of a health care transaction that is covered by a third party payer can these transactions be fully automated.

We believe that the adoption of a robust NHPI standard for use within the 5010 Version of the X12 health care standard transactions will achieve this goal in the most expeditious manner. Historically, waiting for the implementation of a new version of the transaction is likely to entail extended delays. We cannot afford another delay, such as the nine years to move from the 4010 to 5010 transactions, to solve the current problems. While the adoption of an NHPI as we have proposed would not entirely eliminate manual processes, we believe it would eliminate their need in 80–85 percent of the transactions in which they are currently required. Thus, the adoption of an NHPI as we have proposed would dramatically increase the value of electronic transactions to the provider community and justify the investment necessary to take advantage of them. This increased automation would lead to significant savings across the health care industry. Indeed, studies have indicated that as much as $210 billion could be saved through standardization and simplification of the health care billing, payment and claims reconciliation process.[1]

[1] PNC Bank (2007); Commonwealth Fund (2007); RAND Corporation (2005); PricewaterhouseCoopers (2008).

APPENDIX A

Following is an example of possible solutions X12 and the Rules Committee can adopt.

NHPI Recommendation for 005010x279 X12 271					
NHPI Type	NHPI Recommended Information	5010 Segment	5010 Loop	5010 Field Description	5010 Field
Type 2	Entity that is responsible for receiving the claim	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101 = PRP (Primary Payer)
				NM108-Identification Code Qualifier	NM108 = XV (NHPI)
Type 2	Entity that is responsible for administering the claim	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101 =PR
				NM108-Identification Code Qualifier	NM108 = XV (NHPI)
Type 1	Plan/product type 'description,' not to be confused with the Claim Filing Indicator which is the Plan/Product code. The 271 Plan/Product list should be 'synched' with the 835.	EB-SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION	Loop 2110C	EB05-Plan Coverage Description	EB05 = Plan name or product name
Type 2	Entity that has the direct contract with the provider	REF-SUBSCRIBER ADDITIONAL IDENTIFICATIO N	Loop 2100C	REF01-Reference Identification Qualifier	REF01 =CT (Contract Number)
				REF02-Description	REF02 = NHPI
Type 2	Fee schedule that applies to the claim	REF-SUBSCRIBER ADDITIONAL IDENTIFICATIO N	Loop 2100C	REF01-Reference Identification Qualifier	REF01=CT (Contract Number)
				REF02-Reference Identification	REF02 =possibly require fee schedule number embedded in Contract Number
Type 2	Entity that is responsible for funding the benefit	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101=P5
				NM108-Identification Code Qualifier	NM108 = XV (NHPI) or 24 (EIN)

Following is an example of possible solutions X12 and the Rules Committee can adopt. Note: These loops are not currently all designed for the information specified. This is an illustration of the type of usage that X12 and any Usage Rules entity would need to create rules to effectively utilize the NHPI for these functions.

NHPI Recommendation for 005010x221 835

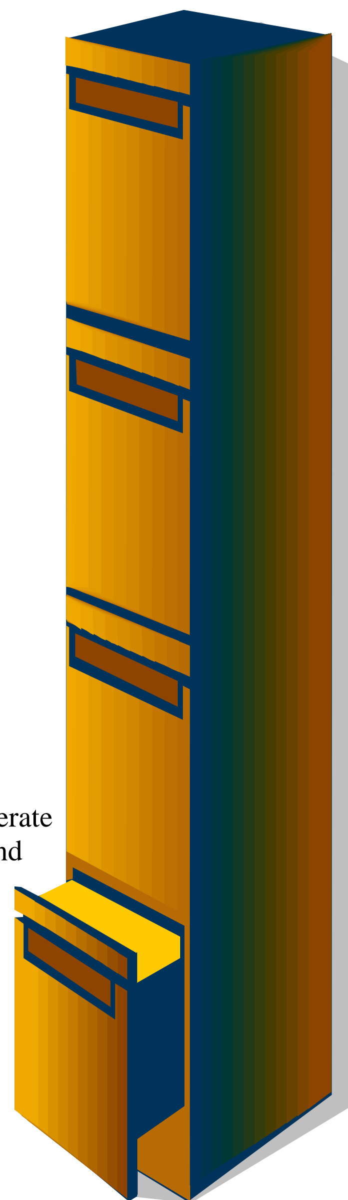
NHPI Type	NHPI Recommended Information	5010 Segment	5010 Loop	5010 Field Description	5010 Field
Type 2	Entity that is responsible for administering the claim	N1-PAYER IDENTIFICATION	Loop 1000A	N103-Identification Code Qualifier	N103 = XV
				N104-Identification Code	N104 = NHPI
Type 2	Entity that has the direct contract with the provider	REF-OTHER CLAIM IDENTIFICATION RELATED	Loop 2100	REF01-Reference Identification Qualifier	REF01 = CE
Type 2	Fee schedule that applies to the claim			REF02-Reference Identification	REF02 = NHPI
Type 1	Plan/product type 'description,' not to be confused with the Claim Filing Indicator which is the Plan/Product code. The 271 Plan/Product list should be 'synched' with the 835.				

APPENDIX B

Entities to receive a National Health Plan Identifier (NHPI)

Each entity (or the subpart it chooses to enumerate) receives only one NHPI number—roles are indicated by the placement of the number within a given transaction.

Which File Cabinet
Identify the entity to receive the claim:
Entities could include: health insurers, employers, PPO pricers (and the variations), third-party administrators, PBMs or other outsourced benefit managers
Recommendation: The NHPI (Type 2) can be used to identify this entity or a routing number contained on or in a standardized health insurance identification card.



Drawer One:
Entity responsible for funding of benefit:
Entities could include: employers (self insured), health insurance issuers, government payers
Recommendation: The NHPI (Type 2) can be used to identify this entity (or consider existing National Employer Identifier for employers).

Drawer Two:
Entity responsible for administering the health care transactions, if different from Drawer One:
Entities could include: PBMs or other outsourced benefit managers; third-party administrators; PPO pricer, pre-pricer, repricer
Recommendation: The NHPI (Type 2) can be used to identify this entity.

Drawer Three:
1) Entity contracts directly with the health care provider, if different from Drawer One/Two:
Entities could include: PPNs, case-by-case fee negotiation companies
Recommendation for entity identifier: The NHPI (Type 2) can be used to identify this entity.

2) Identifier generated by that entity to access the specific contracted fee schedule applicable:
Recommendation for fee schedule identifier: Do not use NHPI to directly enumerate fee schedules. Use NHPI (Type 2) to identify the owner of the fee schedule only and ask standards bodies to develop a fee schedule identifier standard and rules to deliver fee schedules accurately.

Drawer Four:
Patient-specific benefit package:
Products could include: Health insurance products, employee benefit plans or other products defining the patient's coverage
Recommendation: The NHPI (Type 1) can be used to identify the patient-specific benefit package.