



National Health Plan Identifier Frequently Asked Questions

What is the purpose of a health plan identifier?

The purpose of the health plan identifier is to eliminate the ambiguity that currently permeates the electronic standard health care transactions because of the numerous different ways in which health plan functions are performed and the numerous ways the term “health plan” is interpreted. This ambiguity undermines the value of the electronic transactions by requiring repeated manual intervention.

What “problem” does the National Health Plan Identifier (NHPI) solve in the data exchange between covered entities?

A complete health plan enumeration system, coupled with the upcoming implementation of the X12 5010 standards, will finally make it possible to automate 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.

The NHPI can eliminate the ambiguity arising from the following factors:

The first source of ambiguity is 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 pharmacy benefit managers, mental health benefit managers, radiology benefit managers, preferred provider networks and/or fee negotiation companies to perform various administrative functions that would otherwise be undertaken by the health insurer in its administrator role.

Multiple provider contracts are another source of ambiguity. 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 five commercial products. And each of these plan types may be tied to a different fee schedule. To add an additional level of ambiguity, many health care providers also contract with preferred provider networks (PPNs), which in turn “rent” their PPNs 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 the provider does 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.

ERISA preemption adds yet another level of ambiguity. 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.

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.

What is your NHPI proposal?

We recommend that the NHPI must clearly identify: (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). This proposal mirrors the National Provider Identifier (NPI), which similarly creates two types of identifiers. (See Attachment One for a comparison.)

Doesn’t your proposal expand the intent of the legislation? Doesn’t the NHPI refer to the routing number?

To the contrary, both the relevant portion of the Patient Protection and Affordable Care Act (PPACA) and the Health Insurance Portability and Accountability Act (HIPAA) regulations indicate that the NHPI should provide a meaningful identification system for health plans as their identities are relevant to the HIPAA standard transactions. While routing of transactions is certainly a necessary aspect of an NHPI system, an NHPI system that merely routes transactions is not sufficient to accomplish the goal of automating health care transactions.

Sec. 1104 of PPACA refers to existing law on unique health plan identifiers (42 U.S.C. 1320d–2(b)), which states in part that in adopting an NHPI, the Secretary “shall take into account multiple uses for identifiers....” Moreover, the **HIPAA regulations, 45 CFR § 160.103, do not refer to routing numbers. Rather, they define the term “health plan” to cover every party that funds health plan benefits.** (See Attachment Two for the entire text.)

Furthermore, the Centers for Medicare and Medicaid Services (CMS) has consistently pursued specificity in its adoption of other identifiers. For example, CMS refused to allow a large employer made up of separate corporations with their own EINs to apply the parent’s EIN to transactions involving its subsidiary corporations. Rather, CMS insisted that the EIN on the individual’s W-2 form, which identified the direct employer, had to be reported in the enrollment transaction. Similarly, the NPI is very specific, requiring an NPI for a hospital system and also for each constituent separate entity, such as an affiliated surgery center. The same drill down applies to medical practices that have their own NPIs at the entity level (NPI Entity Type 2) and then a separate NPI for each constituent physician or other health care professional (NPI Professional Type 1).

Thus, the enumeration of every entity that acts on behalf of any health plan listed in the regulation in connection with any of the HIPAA Transactions and Code Sets (TCS) transactions—and of each separate benefit plan offered by each of those health plans—is, if anything, more consistent with the intent of the legislation than a system that merely establishes routing numbers.

What is considered the definition of a health plan?

As noted above, the HIPAA regulations, 45 CFR § 160.103, define the term “health plan” to cover virtually every entity that provides or funds health plan benefits. In common usage, the term “health plan” can mean a host of different things: it can range from the specific health insurance product an individual buys to the national company that sells that product and can include each of the intermediaries involved in the multitude of transactions that occur in administering our third-party payment system.

What different functions do health plans perform?

There are four functions related to the health care standard transactions which must be performed by health plans or their agents:

1. transaction receipt (the routing address)
2. funding the patient’s specific benefit plan
3. administering the health care transaction
4. contracting with health care providers for network participation

While in some circumstances all these functions are performed by the same entity, in many circumstances two or more separate entities perform these functions in a single health care standard transaction.

What entities may perform one or more health plan functions?

There are numerous entities that may be involved in various health plan standard transactions. The following is a list of the various entities that commonly perform each of the four functions set forth above:

1. Entity to receive the claim. Entities could include: employer (self insured); health insurer; PPO pricer, pre-pricer or repricer; third-party administrator; pharmacy benefit manager; and other outsourced benefit manager.
2. Entity responsible for funding of benefit (not paying the premium). Entities could include: employer (self insured), health insurance issuer and government payer.
3. Entity responsible for administering the health care transaction. Entities could include: employer (self insured); health insurance issuer; government payer; pharmacy benefit manager or other outsourced benefit manager; third-party administrator; and PPO pricer, pre-pricer or repricer.
4. Entity that contracts directly with the health care provider. Entities could include: employer (self insured), health insurance issuer, government payer, outsourced benefit manager, preferred provider network and case-by-case fee negotiation companies.

Would your proposal require that each of the above listed entities have a separate NHPI number for each function that it may perform?

No. Each of these entities would receive only one identifier. If an entity performs more than one function in any given transaction, that will be indicated by placement of that entity's NHPI in the appropriate fields in the standard transaction.

What value is there in reporting self-funded versus fully-funded employers, and why are you stating they should be enumerated?

Some states report that more than 60 percent of the claims' volume is from self-funded (i.e., self-insured) employers. 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.

Is it also necessary to enumerate the patient's specific benefit plan?

Yes. The current inability of the health care standard transactions (e.g., eligibility response and electronic remittance advice) to clearly and accurately identify the patient's specific benefit plan requires significant manual intervention by all parties. 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 plan 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.

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 seem pretty ubiquitous today.

Is there any additional information that should be conveyed with the NHPI Type 2 identifier?

Yes. We believe the identifier for the entity that has the direct contract with the health care provider should be accompanied by an identifier for the specific fee schedule that will be applied to price the claim.

As noted above, the typical physician practice contracts with 12 different health insurers on average, and each insurer offers up to five commercial plan types with each product potentially having a different fee schedule. The lack of clear fee schedule and product identification is the principle reason that providers cannot (1) determine whether the patient is subject to in-network or out-of-network co-payment, deductible and co-insurance requirements, or (2) automatically reconcile and post claims.

Moreover, the entity that contracts directly with the physician or other health care provider is frequently not the same as the entity that funds or administers the patient’s specific benefit plan. Thus, there might not be any direct relationship between the contracted fee schedule and the patient’s specific benefit plan, and the physician or other provider cannot be certain of the fee schedule simply because they know the identity of the patient’s specific benefit plan.

We recommend that a fee schedule identifier following a national standard format be generated by the entity that contracts directly with the physician or other health care provider. The entity contracting directly with the physician or other health care provider would include these specific fee schedule identifier(s) in the contract, also using this identifier(s) to load this fee schedule into its administrative system to price the specific claims.

We are not proposing real-time adjudication or pre-pricing of the claim. Rather, we are seeking to ensure the physician or other health care provider can identify which of the various fee schedules they have contracted to accept will be applied to a particular claim. To be clear, the fee schedule identifier is just an identifier. We are not proposing that the fee schedules themselves be made public.

Does the AMA require or support intelligence in the chosen NHPI number?

The AMA proposal does not take a position on the composition of the NHPI. Quite simply, the AMA proposal identifies the things that need to be enumerated so that health care transactions can be fully automated: the patient-specific benefit plans and the entities that perform health plan functions relevant to the standard electronic transactions. To the extent there are existing identifiers that could be used consistent with this robust NHPI system, so much the better.

Wouldn’t your proposal result in millions of new identifiers being created?

As noted above, the AMA proposal does not take a position on the composition of the NHPI. To the extent there are existing identifiers that meet the standard that is adopted, we see no reason that they could not be continued. To the extent our proposal calls for enumeration of an entity that may perform more than one health plan function, we do not propose that that entity be required to get more than one

identifier. If an entity plays more than one role in any given transaction, those functions would be indicated by placement of the NHPI in the appropriate fields in the transaction.

To the extent that new numbers are necessary, we believe the cost of the enumeration is far outweighed by the benefits that will be achieved by all parties through increased automation. Health care transactions must 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 transactions is likely to entail extended delays. We cannot afford another delay, such as the nine years to move from the 4010 to 5010 transaction, to get to full automation.

Attachment One

National Provider Identifier (NPI), Definitions from the NPI Final Rule

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.”

National Health Plan Identifier (NHPI) Proposal

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, pharmacy benefit manager (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);¹ 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.

Attachment Two

45 CFR § 160.103 (Portions defining “health plan”)

Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg–91(a)(2)).

Health plan includes the following, singly or in combination:

- (i) A group health plan, as defined in this section.
- (ii) A health insurance issuer, as defined in this section.
- (iii) An HMO, as defined in this section.
- (iv) Part A or Part B of the Medicare program under title XVIII of the Act.
- (v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, *et seq.*
- (vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).
- (vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.
- (viii) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- (ix) The health care program for active military personnel under title 10 of the United States Code.
- (x) The veterans health care program under 38 U.S.C. chapter 17.
- (xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- (xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, *et seq.*
- (xiii) The Federal Employees Health Benefits Program under 5 U.S.C. 8902, *et seq.*
- (xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, *et seq.*
- (xv) The Medicare+Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w–21 through 1395w–28.

(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

(xvii) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg–91(a)(2)).

(2) *Health plan* excludes:

(i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg–91(c)(1); and

(ii) A government-funded program (other than one listed in paragraph (1)(i)–(xvi) of this definition):

(A) Whose principal purpose is other than providing, or paying the cost of, health care; or

(B) Whose principal activity is:

(1) The direct provision of health care to persons; or

(2) The making of grants to fund the direct provision of health care to persons.

Group health plan (also see definition of health plan in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg–91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan.

Health insurance issuer (as defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg–91(b)(2) and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.