



*Partnering for Electronic Delivery
of Information in Healthcare*

**Statement to the
NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS
SUBCOMMITTEE ON STANDARDS**

May 3, 2017

Presented By: Laurie Darst
Chair, WEDI Board of Directors
WEDI Health Plan Identifier (HPID) Workgroup Co-chair

Members of the Subcommittee, I am Laurie Darst, Chair of the Workgroup for Electronic Data Interchange (WEDI) Board of Directors. I would like to thank you for the opportunity to present testimony today on behalf of WEDI concerning the future of the Unique Health Plan Identifier (HPID) under the Administrative Simplification provisions of the Affordable Care Act (ACA).

WEDI represents a broad industry perspective of providers, clearinghouses, payers, vendors and other public and private organizations that partner to collaborate on industry issues. WEDI is named as an advisor to the Secretary of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and we take an objective approach to resolving issues.

Background

WEDI has collected feedback from its members on the HPID to report to the Subcommittee since the hearings in July 2010. Over the years, we have engaged our membership through several Policy Advisory Groups (PAGs), Technical Advisory Committees (TACs) and sessions during conferences or forums on the subject. Initially WEDI submitted several sets of recommendations on how HPID might be formulated to meet industry needs, based on the proposed rule. We believe the agency did consider and incorporate many of these recommendations as part of issuing the final rule. Once health plans started to delve into the enumeration requirements from the final rule however, there was a realization that they would need to enumerate to a much greater granularity than they perceived from the proposed rule. The realities of the impact to the existing HIPAA-adopted

transaction base started to become more understood because of these industry discussions. More and more challenges to business as usual started to emerge, which I will cover in greater detail below.

In July 2015, the Centers for Medicare & Medicaid Services (CMS) issued a “Request for Information (RFI) on the Requirements for the HPID”. At that time, WEDI held a TAC to provide a forum for healthcare organizations to convene, discussing in detail issues relating to regulatory provisions for the HPID. The outcome of the discussion was a set of comments that were reviewed and approved by the 2015 WEDI Board of Directors’ Executive Committee. WEDI found after holding many discussions with its members upon publication of the Final Rule in 2012 that perceptions of what HPID would provide the industry versus the realities of how health plans intended to enumerate had changed.

We have not heard any new feedback from WEDI members which would modify our comments to HHS/CMS in response to the RFI in July 2015, namely that

- HPID not be used in transactions
- HPID is not needed at all, i.e. there is no need for HPID (or OEID) enumeration

To further clarify WEDI’s comments, I would like to address the specific questions from the Subcommittee.

1. What health plan identifiers are used today and for what purpose?

WEDI’s collaboration with ASC X12 on the “What is the Difference Between a Health Plan and a Payer?” issue brief (see Appendix A) in 2014 highlighted that health plan identifiers are not used in standard transactions currently. Rather, it is payer identifiers that are used to drive the routing of transactions between the various trading partners. Health Plans are defined under HIPAA regulatory provisions as “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)).”¹ while Payers are the intended entities that are responsible for final processing of:

- Claims in order to return remittance advices
- Inquiries (eligibility, services review or claim status) in order to return the corresponding responses
- Enrollment of or premium payment for members²

¹ *Code of Federal Regulations*, General Administrative Requirements, title 45, sec. 160.103.

² WEDI, “What is the Difference Between a Health Plan and a Payer?”, July 24, 2014, <http://www.wedi.org/knowledge-center/white-papers-articles/issue-briefs/page/2/>.

2. What business needs do you have that are not adequately met with the current scheme in use today?

WEDI members have not identified any business needs, which are not being met by the identifiers currently in use.

3. What benefits do you see the current HPID model established by the HHS regulation provide? Does the model established in the final HPID rule meet your business needs?

WEDI members have not identified any benefits to the HPID model as established by the final regulation. Implementation of the provisions within the HPID regulation would create challenges and barriers to the workflows and transaction streams currently in use.

4. What challenges do you see with the current HPID model established by HHS?

Use of HPID in Transactions

As we have indicated previously, the industry has long ago solved the routing issues that were prevalent before moving to use of electronic transactions under HIPAA. Providers, payers and clearinghouses have worked through identifying the entities to move the transactions from provider to payer and vice versa. Infrastructures were built around these known relationships and a significant number of participants agreed that existing Payer IDs meet stakeholder needs for transaction routing. Even if the HPID to Payer ID relationship was a one-to-one, which we know would ultimately not be the case, exchanging one set of numbers for another set that is currently functioning affords no administrative simplification. Rather, it creates the potential for greater disruption to current business flows. There was overwhelming agreement that there are potential risks and disruptions in the event transactions would change to use the HPID in lieu of current Payer IDs.

HPID Enumeration Structure

Many self-insured group health plans do not directly administer their health plan operations, employing a third party administrator today. Under the HPID business model, these plans do not conduct standard electronic transactions and with the provisions of the HPID Final Rule applying to health plans, not just health plans that conduct standard transactions, there was concern that many self-insured health plans continued to be unaware of the requirements that would apply to them.

Coupled with the confusion surrounding self-insured plans, the concern over greater granularity as referenced earlier, continued to cause industry concern. When WEDI convened its TAC in 2015 to respond to CMS' RFI, we found no change in the industry level of confusion over enumeration requirements in terms of which entities were required to enumerate and the level of granularity required under the rule. Confusion was apparent across the entire spectrum of stakeholders. Health plans had varying interpretations of the degree to which they must enumerate, but for many, it was a much greater degree of granularity than the payer IDs they used then (and now) to exchange electronic transactions with their trading partners. There were reports of payers using from one to

five identifiers that would have to enumerate to greater than 50 under the HPID final rule. Providers expressed confusion over how these new IDs would relate to those they currently used to identify their payer trading partners. It was the lack of understanding of HPID's true intended use, i.e. the business case and value that caused confusion across all stakeholders. As a result, WEDI modified its prior comments in support of HPID enumeration to no longer support a need for further HPID enumeration beyond those already issued and to no longer support a need for their use.

5. What recommendations do you have going forward regarding health plan identifiers and an HPID final rule established by HHS?

WEDI's comments from July 2015 remain the same today, that:

- HPID not be used in transactions
- HPID is not needed at all, i.e. there is no need for HPID (or OEID) enumeration

WEDI supports the continued efforts of all stakeholders towards achieving administrative simplification within healthcare and supports focusing collaboration and communication among industry participants on topics that bring value to the industry. Members of the Subcommittee, I thank you for the opportunity to testify today and am happy to address any questions.

WEDI Strategic National Implementation Process (SNIP)
HPID Workgroup

What is the Difference Between a Health Plan and a Payer? Issue Brief



*Partnering for Electronic Delivery
of Information in Healthcare*

July 24, 2014

Workgroup for Electronic Data Interchange

1984 Isaac Newton Square, Suite 304, Reston, VA. 20190

T: 202-684-7794//F: 202-318-4812

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I. Introduction

The bulk of the healthcare industry's concerns related to the Unique Health Plan Identifier (HPID) land in two categories:

1. Definition of Controlling Health Plan (CHP) and what is specifically required for health plan enumeration.
Note: This issue brief does not address this concern.
2. Required use of the HPID in the ASC X12 transactions

The Workgroup for Electronic Data Interchange (WEDI) has conducted ongoing conversations with the Centers for Medicare & Medicaid (CMS) and through those discussions, identified that there are differences in verbiage usage between the terms "health plan" and "payer". By and large, the healthcare industry tends to use the terms "health plan" and "payer" synonymously. The HIPAA regulation, however, defines "health plan" differently than the way the industry commonly uses the term. This variation in terminology usage has also created additional interpretation issues.

As a result, WEDI engaged ASC X12 to develop this issue brief to aid the industry in understanding the difference between the terms "health plan" and "payer".

II. Definitions

Health Plan

The HPID Final Rule relies on the definition of "health plan" under HIPAA in 45 CFR §160.103:

"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))."

The Code of Federal Regulations further defines what types of plans are included in a "health plan".

Payer

The term "payer" as used in the transactions is defined as the intended entity that is responsible for one or more of the following:

- final processing of the claim in order to return the remittance advice.
- final processing of the inquiry (eligibility, services review or claim status) in order to return the response (eligibility, services review or claim status).
- final processing of the (member) enrollment or premium payment.

Note: This definition excludes any business associate used to create or receive a transaction on behalf of a payer, e.g. a clearinghouse processing eligibility inquiries and response on behalf of a payer Information Source.

Examples of the value of a payer ID include, but are not limited to NAIC code, EIN, etc.

III. Usage

The role of payer is distinct from the role of a health plan. Even though an entity can be in both roles, not all payers are health plans and not all health plans are payers.

Usage in transactions relies on the identification of the role the entity being identified is playing. While a health plan can be a payer, in the transactions, the entity is being identified for its role as a payer not as a health plan.

Payer

Current use of the payer identification data elements in the ASC X12 transactions is to identify the entity in the role of a payer. Examples of payer identification include the following:

- A health plan, *Self-funded Group A*, contracts with *Insurer A*, also a health plan, as their third-party administrator. *Insurer A* sends and receives the transactions on behalf of *Self-funded Group A* with providers and clearinghouses. *Insurer A*, although a health plan, acts in the role of a payer when conducting business for *Self-funded Group A*. Therefore, it is appropriate to identify *Insurer A* with a payer ID in their role as a payer.
- A health plan, *Insurer B*, is a subsidiary of *Parent Company C*, who does not meet the definition of a health plan. *Parent Company C* is conducting the transactions for *Insurer B*. Therefore, it is appropriate to identify *Parent Company C* with a payer ID in their role as a payer.
- A health plan, *Health Plan C*, contains a functional unit within its business structure that is the payer, *Payer C*. Therefore, it is appropriate to identify *Payer C* with a payer ID when conducting transactions to identify themselves in the role of a payer.

Health Plan

In instances when a health plan chooses to identify itself as a health plan in a transaction, the HPID of the health plan is the identifier that would be used after the HPID Final Rule compliance date. An example of this is payer, *Insurer H*, collects premium dollars from members for health plan, *Self-funded Chamber of Commerce*. *Insurer H* sends a premium payment transaction to *Self-funded Chamber of Commerce*, who is identified as a health plan premium receiver using *Self-funded Chamber of Commerce's* HPID.

Summary

If a health plan, third-party administrator, administrative services organization, or a different entity currently is identified in standard transactions as a payer, it would continue to do so. If the entity currently is identified as a health plan (and continues to be identified as a health plan after November 7, 2016) in standard transactions, it must use an HPID.

IV. Acknowledgements

- Laurie Burckhardt (ASC X12)
- Laurie Darst (WEDI HPID Workgroup)
- Gail Kocher (WEDI HPID Workgroup)
- Margaret Weiker (ASC X12)

The co-chairs wish to express their sincerest thanks and appreciation to the CMS Office of E-Health Standards & Services.