BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

on

Unique Health Plan Identifier (HPID)

Presented by:

Gail Kocher, Director, National Standards

BLUE CROSS BLUE SHIELD ASSOCIATION

May 3, 2017

Good morning. My name is Gail Kocher and I am the Director, National Standards, for the Blue Cross Blue Shield Association. BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for one in three Americans – across all 50 states, the District of Columbia and Puerto Rico.

On behalf of BCBSA and the Plans, I would like to thank you for the opportunity to respond to the Subcommittee on Standards' questions and provide our perspective on the future of the Unique Health Plan Identifier (HPID). While HPID is ultimately a local Plan business decision, our comments today are reflective of feedback from all Blue Plans.

We continue to strongly support the goals of HIPAA Administrative Simplification to promote efficiency and reduce the costs of administrative transactions. We do not believe, however, that implementation of the requirements as specified in the Unique Health Plan Identifier (HPID) Final Rule will meet these objectives. Overall, we believe that policy changes are warranted.

Therefore, we recommend HHS retract the rule for the following reasons:

- The industry does not need enumeration requirements for the HPID.
- The industry does not need the ability to obtain OEIDs.
- The industry does not need to use HPID in HIPAA adopted standard transactions.

I will address the Subcommittee's questions to provide detailed rationale for these recommendations.

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

The premise of HPID appeared to be that a health plan identifier and a payer identifier are synonymous, but that is not the case. While some health plans are also payers, this is not true for all health plans and that is why currently, identifiers within the HIPAA standard transactions identify a payer, e.g. the entity that will adjudicate a claim and potentially reimburse for services rendered.

Today, trading partners are successfully using identifiers, including the National Association of Insurance Commissioners (NAIC) numbers and federal tax identification numbers to identify payers in HIPAA standard transactions. In addition, these and other identifiers, i.e. the HIOS identifiers, are used to fulfill other reporting needs, including reporting to CMS or the Department of Labor. Within the Blue System, we utilize proprietary Plan codes to exchange data between Plans and BCBSA, and we are aware that some clearinghouses and software vendors have implemented these codes as identifiers for Plans as payers within their systems and software and for use in sending transitions to Plans.

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

We have not identified any business needs that are not and cannot be met by the current identifiers and their schemas in use by the Plans and BCBSA, between each other and with our trading partners.

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?

We have not identified any benefits to the current HPID model as established by the final rule. Rather, that model would create additional burden on BCBSA, the Plans and all our trading partners. These burdens will be identified in the discussion of challenges under the next question.

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

The current HPID model is predicated on an enumeration schema of one entity, i.e. a health plan, to ostensibly solve a perceived issue with the routing of standard transactions between other entities, i.e. payers and their trading partners. Modifying current processes and procedures to use an HPID rather than either a payer ID or some other identifier would be disruptive, costly and add no value for any stakeholder. HPID enumeration would be a one-to-one to existing payer IDs for some Plans; other Plans have indicated a enumeration under the HPID would be significantly more granular.

Regardless which enumeration schema a Plan ends up with, changing to the use of HPID in transactions from current payer IDs becomes costly, not just for Plans but also for all stakeholders. Changes would be required within not just front-end translators but internally anywhere those identifiers are used as part of processing standard transactions. Often times data from standard transactions impacts other downstream processes, including reporting to CMS and other regulatory bodies, which then impacts the downstream applications and not just the electronic data interchange (EDI) systems. Implementing HPID as it was in the final rule in transactions would result in the misrouting of transactions, which would be very disruptive to claims processing, imposing very significant costs, confusion and workloads on clearinghouses, self-funded plans, payers, providers and patients. Providers, the intended primary beneficiaries of the HPID, have already experienced much of the anticipated benefits and cost savings through widespread usage of payer IDs

The introduction of an enumeration requirement, which included self-funded plans that do not typically conduct standard transactions, has created significant industry confusion and burden. The burden is primarily on traditional payers and third-party administrators supporting these groups, but would likely be passed onto the provider community if such HPIDs were subsequently used in standard transactions. As most self-funded plans are not conducting transactions currently, they found the HPID Final Rule requirements highly confusing, from whether and how the requirements were applicable to them, to what they would need to do with any HPIDs they obtained.

We also note that the HPID Final Rule indicated that implementation of the HPID would reduce the number of pended claims and increase the use of electronic healthcare transactions. We see no evidence of any significant number of claims being pended due to either misrouting or invalid payer identification today; rather, a change in identifiers is likely to result in greater volumes of pended claims and greater volumes of files that cannot be accepted for processing. We have no reason to believe that use of the HPID will result in the greater adoption of standard transactions. The volume of healthcare claims submitted electronically is already at a very high volume and, as reflected in the testimony of numerous stakeholders during the June 2015 NCVHS Review Committee hearings, the reason for low utilization of other transactions had little or nothing to do with lack of an HPID. Given our comment above, we would conclude that the potential savings documented in the final rule will not be realized and that it is most likely the implementation as currently specified would yield a negative ROI for all stakeholders.

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

HHS should retract the rule. The industry does not need enumeration requirements for the HPID, it does not need the ability to obtain OEIDs, and it does not need to use HPID in HIPAA adopted standard transactions.

While there have been a number of changes to the nation's healthcare system since issuance of the HPID Final Rule, we are not aware of any, which have changed our perspective on the HPID. What has changed since Sept. 5, 2012, is our awareness of the complexity and lack of value of the HPID, indicating little or no opportunity for the positive return on investment (ROI) that was indicated in the Final Rule.

As Plans were developing their enumeration strategies, they became increasingly aware of the complexity associated with enumeration decision making, especially for large organizations with numerous subparts. This was further complicated with confusion surrounding self-funded, fully-insured and combination fully insured and self-funded groups. This, coupled with the projected cost and lack of ROI, has significantly changed our perspective on the need, value or benefits of fully implementing the rule as currently written. These concerns were well articulated by the NCVHS in its September 2014 letter to the Secretary and we would like to restate them here:

- "Lack of clear business need and purpose for using HPID and Other Entity Identifier (OEID) in health care administrative transactions.
- Confusion about how the HPID and OEID would be used in administrative transactions, including strong concerns that HPID might replace the current Payer ID widely adopted and used throughout the industry.

- Challenges faced by health plans with respect to the definitions of controlling health plan (CHP) and sub-health plan (SHP).

- Use of HPID for group health plans that do not conduct HIPAA standard transactions.

- Cost to health plans, clearinghouses and providers if software has to be modified to account for the HPID."

Lastly, we wish to reiterate the widespread confusion and concerns encountered by the industry, especially from many self-funded plans, as a result of the HPID Final Rule. We anticipate that many self-funded plans are still not aware of the current obligation to enumerate. HPID has and will continue to impose a significant burden on self-funded groups who are not familiar with HIPAA transactions, which causes a downstream burden on third-party administrators, many of which are Blue Plans.

Given the number of mandates with implementation dates in the next few years and the objectives of Executive Order 13771, "Reducing Regulation and Controlling Regulatory Costs", we continue to encourage CMS to consult the National Committee on Vital and Health Statistics to develop a strategic road map. This road map should limit the imposition of private expenditures required to comply with Administrative Simplification provision regulations. This road map should balance all mandates from the ACA, not just Administrative Simplification provisions, along with other ARRA/HITECH mandates, to work towards avoiding bottlenecks and overlapping resource commitments and helping the Secretary meet the objective of the President's Executive Order on regulation. We would also request that the NCVHS work with industry stakeholders in developing such a road map.

We appreciate the opportunity to testify and I would be happy to answer any questions.