PBGH
PACIFIC BUSINESS GROUP ON HEALTH

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Statement for the Record

Pacific Business Group on Health

Hearing before the National Committee on Vital and Health Statistics (NCVHS)

"Hearing on the Health Plan Identifier - an identifier under the Health Insurance Portability and Accountability Act (HIPAA)"

May 3, 2017

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Good morning co-chairs Goss and Coussoule, and other distinguished committee members. Thank you for inviting me here today. My name is Kristy Thornton, and I serve as Senior Manager of Transparency at the Pacific Business Group on Health (PBGH). I would like to express our appreciation to the committee for convening this hearing on the Health Plan Identifier.

PBGH is a coalition of large health care purchasers, including both private employers and public agencies. Our coalition drives quality and affordability improvements across the U.S. health system. PBGH consists of 75 organizations that collectively spend more than $45 billion per year purchasing health care services for almost 12 million Americans. PBGH members include many large national employers such as Walmart, Boeing, Tesla, Target, Disney, Intel, Bechtel, Chevron, Wells Fargo, and Safeway, as well as public sector employers such as CalPERS and the City and County of San Francisco.[i]

My comments today will focus on the key features of a Health Plan Identifier to drive administrative simplification, and meet purchaser business needs in transparency and value-based payment initiatives.

First, I will discuss the Health Plan Identifier itself.

PBGH does not take a position on the specific enumeration typology of the Health Plan Identifier, but instead advocates for an approach that meets the following five criteria, aligned with purchaser business needs.

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1. National
2. Standard
3. Unique
4. Embedded with information on the major payer, the subsidiary, and type of plan
5. Consistently enforced in all transactions involving an entity performing a health plan function across the public and private sectors

The committee should identify specific enumeration typologies for the Health Plan Identifier that meet these criteria, as the existing array of Employer Identification Numbers, Tax Identification Numbers, National Association of Insurance Commissioners Identification numbers, health care clearinghouse and health-plan assigned proprietary numbers do not. We recommend reviewing enumeration typologies by the National Association of Health Data Organizations and others in the field of public health.

Next, I will discuss how a Health Plan Identifier meeting the aforementioned criteria will advance administrative simplification and reduce waste.

Quality and affordability improvements across the U.S. health system require a clear, standard, and reliability automated system of health care transactions as a baseline condition. Progress has been made in this area, but the Health Plan Identifier lags behind, failing to properly represent the true complexity of administrative and payment processing functions. It is critical to recognize that the term “health plan” is not sufficiently specific to have a clear meaning. There are many different entities that provide, arrange, reimburse, contract, or pay for the cost of health services, or

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administer these services on behalf of a payer. These entities can include insurance companies, self-insured employers, government payers, third-party administrators, health maintenance organizations, pharmacy benefit manager, dental benefits administrators, and others. Each of these different entities create a constellation of provider networks, benefits features, prior authorizations, fee schedules, and contract requirements that comprise a patient-specific benefit plan.

Comments as to the cost of software modification to implement the Health Plan Identifier fail to recognize the cost of the status quo. The lack of a Health Plan Identifier adds a layer of manual work into payment transactions that is very costly. Every day, providers and payment entities engage in unnecessary administrative activities to reconcile patient eligibility, correct billing errors, and re-send rejected transactions because a standard Health Plan Identifier does not exist. The Institute of Medicine has estimated that this type of excess administrative costs is worth a staggering $190 billion per year.[ii] We, as purchasers, no longer find it justifiable to pay for this waste.

Now I will discuss how the Health Plan Identifier will meet purchaser business needs in transparency and value-based payment initiatives.

PBGH members believe that increased transparency and value-based payments are the keys to making improvements in the quality and affordability of health care. One of the few robust sources of objective, reliable data for purchaser transparency and value-based payment efforts are state-based all-payer claims databases, and private-sector multi-payer claims databases. However, these databases need the ability to triangulate among different third party payment intermediaries back to a major payer and member to create complete records of care. The All-Payer Claims Database

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Council Common Data Layout[iii] has included the Health Plan Identifier since 2011 for this very purpose– but it currently lays empty due to the lack of enforcement.

Proper health plan identity management is essential to claims-based initiatives to support network and benefit design, provider improvement, alternative payment models, and consumer engagement. Consider these three critical examples:

1. Total cost of care: Assessing the total cost of services on a per member per year basis requires a standard method for linking patient services across all settings and payment intermediaries
2. Value-based insurance design: Aligning patient's out-of-pocket cost, such as copayments and deductibles, with the value of health services[iv] requires a more granular way of identifying sophisticated health benefit packages, across a wide variety of contracts and benefits administrators in a standardized manner.
3. Transparency: Health plan enrollees, especially those in high-deductible health plans and exchanges, need useful price calculator tools that include plan- and provider-specific total costs and expected out-of-pocket costs for common procedures and conditions. This is again made possible by a unique, standard health plan enumeration system.

Simply stated, identify management is core to accountable care.

In closing, many of our purchasers operate in a business environment that has been "data-enabled" for some time, and wonder why health care does not operate in the same way. At this point in the evolution of technology the key barrier to progress in health care information is now the agreement

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and commitment of stakeholders. We urge this committee to help modernize health care business practices, and enforce the use of a unique, national, standardized Health Plan Identifier with embedded information on the major payer, the subsidiary, and type of plan.

Thank you again for the opportunity to provide input on this important topic. I am happy to answer any questions the committee may have.

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[i] Full list of PBGH members can be found at www.pbgh.org/about/members

[ii] Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. National Academies Press; 2013.

[iii] Learn more about the APCD Council Common Data Layout at https://www.apcdcouncil.org/sites/apcdcouncil.org/files/media/publications/draft_cdl_02272017.pdf

[iv] Learn more about Value Based Insurance Design at http://www.vbidhealth.com/index.php