Statement of America's Health Insurance Plans
to the
National Committee on Vital and Health Statistics
Subcommittee on Standards
Regarding the Health Plan Identifier
May 3, 2017

Introduction and Overview

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Today I am testifying on behalf of AHIP's members with respect to the future of the health plan identifier (HPID). AHIP has actively engaged in conversations related to HPID throughout the implementation of the Affordable Care Act (ACA). We provided insight to both the Administrator of the Centers for Medicare and Medicaid Services (CMS) and the National Committee on Vital and Health Statistics (NCVHS) during the regulatory process leading up to the 2014 compliance date. AHIP supported the enforcement delay announced on October 1, 2014. Prior to the non-enforcement announcement, health plans faced challenges in HPID enumeration due to, the overly-complicated and arbitrary structure of controlling health plans (CHPs) and subhealth plans (SHPs) that form the basis for the HPID and other entity identifier (OEID) enumeration, outstanding questions on the requirements for different entities (e.g., self-insured, fully insured plans and the health plan TPAs), and technical challenges with enumeration using the Health Plan and Other Entity Enumeration System (HPOES).

More importantly, even if these outstanding questions and technical issues were resolved, there does not appear to be a clear business need or added value for using HPID in health care administrative transactions. HPID is an outdated solution attempting to solve a problem that no longer exists. The industry has widely adopted payer identifiers (payer IDs) for routing standard transactions and this solution is working successfully. Implementing HPID would undermine the current use of payer IDs and would likely lead to misrouted transactions and added administrative burden and cost.

We recommend that CMS not move forward with implementing HPID for use in transactions, for health plan certification, or for any other purposes and withdraw the existing HPID regulation. This is consistent with prior AHIP comments[1] to CMS in response to

[1] America's Health Insurance Plans Comment Letter to the Acting Administrator of CMS. July 28, 2015.

the 2015 Request for Information (RFI)[2] on the future of HPID as well as recommendations provided to both CMS and NCVHS in 2014 in advance of the enforcement discretion announcement. Since we last made these comments, there have not been new developments in the industry that would create a new need or value proposition for HPID.

Response to NCVHS Questions

To assess the current industry landscape and any potential new factors that could merit the use of HPID, NCVHS requested testifiers respond to a series of questions. AHIP's responses are below:

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

   Payer IDs are currently used to route transactions between providers, payers, and clearinghouses for purposes of claims, eligibility inquiries, enrollment, and premium payment. Health plan identifiers are not used in transactions.

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

   We have not identified any unmet business needs with respect to transaction identifiers. Stakeholders have built infrastructure around payer IDs and these identifiers are embedded throughout transaction routing. Payer IDs are successfully meeting stakeholder needs to route transactions.

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?**

   We do not see any value in the HPID model established by current HHS regulations. Requiring issuers to obtain and maintain HPIDs or OEIDs would impose unnecessary administrative costs with no anticipated return on investment. We do not see value in using the HPID in transactions as it would be duplicative of payer IDs. Use of both the HPID and payer ID would be confusing and disruptive to the flow of standard transactions.

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

   The HPID is unworkable in its current form. There are challenges with the enumeration structure, lack of clarity related to requirements for different group health plans that do not conduct standard transactions, and significant concerns about the negative impact of using HPID in transactions. There are also challenges with the proposed linkage between HPID and health plan certification.

   Enumeration Structure
   HPID regulations, as created, veered away from the original intent of HPID, which was to facilitate easy routing of administrative transactions. The overly complicated structure of CHPs and SHPs would require HPID and OEID enumeration at a granular level. The

[2] Request for Information Regarding the Requirements for the Health Plan Identifier. 80 FR 30646. May 29, 2015.

enumeration requirements align state-level product filings with HPID, but this arbitrary distinction does not reflect how claims are processed. This could result in a company having multiple HPIDs for claims that are all processed at the same location, and significantly more HPIDs than payer IDs, creating unnecessary complexity for routing transactions.

Enumeration Requirements for Group Plans that Do Not Process Transactions
The enumeration requirements created significant uncertainty around the requirements for self-insured, fully insured, and ASO groups. The rules appear to create a significant burden for self-insured groups that do not conduct their own transactions but would still be required to obtain HPIDs. This created an added burden for third party administrators (TPAs), who conduct transactions on their behalf, to obtain and maintain HPIDs on behalf of self-insured groups and incorporate their HPIDs into routing. This is another example of the unnecessary complexity and added administrative burden created by the HPID regulations.

Use of HPID in Transactions
As discussed above, HPID is an outdated solution to a problem that no longer exists and would not provide value if implemented. The industry has widely adopted payer IDs to route standard transactions for purposes of claims, eligibility inquiries, and enrollment and payment transactions. While payer IDs may vary in length or format, they work well for the industry to route transactions. Use of the payer ID negates the need to adopt a new, complicated identifier with an unclear business case beyond the routing of transactions. If HPID was adopted alongside payer IDs, this would result in added complexity, confusion, and likely misrouting of transactions with no added value.

HPID in Health Plan Certification
The Administrative Simplification: Certification of Compliance for Health Plans proposed rule published in the *Federal Register* January 2, 2014 (79 FR 297) proposed the use of HPID as the basis for health plans to meet the certification requirement required in Section 1104 of the Affordable Care Act. The enumeration structure required for HPID does not align with the objectives of health plan certification and would result in health plans certifying compliance at a very granular level, as opposed to a system or company level. Certification by HPID would not accurately reflect the way health plans conduct transactions and would likely lead to unnecessary duplication in certification and additional administrative burdens for health plans.

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

   The concerns we identified in our 2015 response to the RFI as well as those concerns voiced by NCVHS in its 2014 letter to the Secretary continue to be true today. We do not see value in requiring health plans to obtain HPIDs or OEIDs or use them in transactions. Doing so would not add value for the industry and would result in significant administrative costs without an expected return on investment. **We continue to recommend that CMS remove the existing regulation and not require HPID enumeration or its use in transactions.**

With respect to health plan certification, we recommend CMS issue a new proposed rule with a certification process that does not depend on HPID. Instead, CMS should use another, existing identifier (e.g., NAIC IDs, employer identification number (EIN)) that would allow health plans to certify compliance at the company or system level, rather than the granular HPID level. This would better reflect the way issuers process transactions and provide a more accurate picture of compliance.