
# The Future of the Health Plan Identifier (HPID)

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Madam/Mister Chair and members of the Standards Subcommittee. My name is Dave Nicholson and I am the owner of a medical billing company, PMI, based in Maryland. I am here today representing the Healthcare Business Management Association. Some of you who have heard me testify on behalf of HBMA in the past, may recognize the change we have made in our name.

Until recently, HBMA stood for Healthcare Billing and Management Association. However, given the changing nature of the healthcare system and the breadth of services our members perform for their physician and hospital clients, it is clear we are no longer just "billing" companies but instead, we perform a broad array of business services for our clients. Thus, changing the name to the Healthcare Business Management Association was a reflection of the changing nature of not only our industry, but how the business of healthcare is evolving.

HBMA members process medical billing, physician billing, insurance billing, and other claims integral to the healthcare delivery system. HBMA members also perform all of the physician's practice management functions, accounts receivable management, medical billing consulting, as well as assistance in the preparation and completion of provider enrollment forms and other practice management services.

HBMA members typically provide services to specialty physician groups and primary care practices and process Medicare, Medicaid, and private health insurance claims. HBMA members collectively submit a significant percentage of all initial medical claims to the country's governmental and commercial payors. Those claims not submitted by HBMA member companies are usually submitted directly by the provider.

Although HBMA membership includes some of the nation's largest billing companies (1,000+ employees submitting millions of claims), the typical HBMA member is a small to medium sized business employing, on average 40 – 50 individuals. Nearly half of HBMA members have clients in more than one state.

HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

We appreciate the opportunity to talk with you today about the future of the Health Plan ID.

At the outset, I want to reiterate a statement made by an HBMA representative to this panel in 2010 when NCVHS held a hearing on plans to adopt the HPID requirements:

> In general, HBMA supports the adoption and use of Health Plan Identifiers; although it must be stated that we are skeptical that the savings CMS believes will accrue as a result of this initiative can be achieved. It appears that some of the assumptions made about the utility and value of HPIDs when HIPAA was enacted in 1996 were overstated.
>
> The inability to achieve the presumed administrative savings and efficiencies originally assumed by adoption and use of an HPID is not sufficient reason to scrap the idea and there may be future uses for the ID numbers that will allow unnecessary costs to be avoided.

In preparing for this hearing, we contemplated just cutting and pasting the testimony we presented in 2010 under a new header because many of the same questions and concerns we addressed in 2010, are relevant today.

Since that hearing, HHS has adopted (but suspended enforcement of) Health Plan identifier standards. That rule adopted the HPID as the standard unique identifier for health plans and defines the terms ‘‘Controlling Health Plan’’ (CHP) and ‘‘Subhealth Plan’’ (SHP) to differentiate health plan entities that are required to obtain an HPID, and those that are eligible, but not required, to obtain an HPID. This rule requires all covered entities to use an HPID whenever a covered entity identifies a health plan in a covered transaction. But again, enforcement of that rule was suspended.

HBMA continues to support the concept of a Health Plan Identifier but I think it is important that we recognize not only the benefits of an HPID but also the limitations. HPIDs are not a magic bullet that will miraculously solve many of the administrative complexity problems still confronting healthcare providers.

Mr. Chair, per your request, I will address each of the questions you raise in order.

1. What health plan identifiers are used today and for what purpose? Visual work flows are welcome.

Health Plan identifiers are used today despite the fact that they are optional rather than mandatory for most plans. However most HPIDs are at the macro or health plan parent level, and are not necessarily specific to the product that the patient is covered by at the time of the visit. They may be considered more of a routing number or zip code.

In order to begin meeting the needs of our physician clients, however, the Health Plan IDs must be used in conjunction with a policy identification number.

The Health Plan ID is generally sufficient to get you into the ball park, to use a sports metaphor but the policy identification number is what gets you to the right section, row and seat.

Health Plan IDs, are, in and of themselves, insufficient to get the level of granular information providers need in order to make patient-specific determinations. And, from conversations with Health Plan representatives, the "policy identification number" is what plans use for internal mapping and tracking purposes.

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

In theory, the Health Plan ID should allow the provider or billing company partner, to ascertain basic information about:

a. Patient eligibility (including the start and end dates of eligibility)
b. The amount, if any, remaining on the patient's deductible
c. Whether a copay should be collected at the time of the visit
d. Where a claim should be sent
e. Whether a "plan" is actually a product of the insurance company whose name appears on the beneficiaries card, or whether this is an ERISA plan or some other product (Medicare Advantage, Medicaid MCO, etc.) hosted by the Plan.

This is assuming, of course, that you have confidence that the information you are receiving is reliable. Some Health Plans are more diligent about updating their beneficiary information than others. As a consequence, most of our clients will "hedge their bets" when it comes to collecting money from the patient, particularly

if the visit is occurring early in the plan year and there is some question about whether the patient may or may not have met his/her deductible.

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?

There is no question that HBMA member companies continue to be frustrated by the myriad of problems they encounter when attempting to get claims properly submitted and paid by health plans. HBMA members and their clients are frustrated by errors arising because a claim was routed to the wrong location, a claim was rejected due to incorrect health plan information being given to the provider by the patient; or the provider has difficulty verifying that a patient was truly enrolled in a particular plan and the benefits of the plan in which the patient was enrolled.

As we stated in testimony before the NCVHS in 2010,

> *"Patients should be able to provide the healthcare provider with their health plan's national identifier, which we believe to be important to this and other reforms, as well as the patient's personal plan identification number. With these two pieces of information, the provider should be able to easily verify enrollment in the health plan, the type of plan and the financial information…"*

In our testimony we also point out

*"If a provider were able to have instantaneous verification of the patient's insurance eligibility – **<u>including the specific financial obligation of the patient</u>** – the provider would know that*

1. *The patient truly is enrolled in the health plan;*
2. *The amount the provider must collect from the patient in terms of co-pay, deductible or both at the time care is provided; and*
3. *The financial obligation (if any) of the insurer.*

Adoption and mandatory use of Health Plan Identifiers could, in theory, move us substantially down the road toward achieving the administrative simplification goal but more will still be required before we realize the type of savings envisioned by Congress when they mandated the HPID as part of HIPAA. The HPID is important,

but it MUST be linked to the beneficiary ID in order to ensure that the provider gets accurate and timely information.

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

Although not specific to the model, the on-going challenge is the reliability of the information you receive from the Health Plan – presuming you get to the correct database within the Plan's system.

For example, let's presume that the identification system works as intended and someone in the physician's front office can successfully pose a query to the Health Plan regarding beneficiary eligibility and deductible status. In this situation, the provider's staff is doing the inquiry the day before the visit so that in the event the patient is not enrolled in the plan, corrective action can be taken before the patient arrives in the physician's office for the visit.

The physician's staff (Provider A) verifies enrollment (generally reliable) and also inquires as to the beneficiary's deductible status. This is increasingly important as more and more patients have high or very high deductible health plans.

The plan states that the patient has not satisfied his/her deductible and has $150.00 remaining. The office staff for Provider A estimates that the total charges for the next day's visit will be $200 meaning that $150 of the charges would be applicable to the patient's deductible and the remainder would be the obligation of the Health Plan.

At the conclusion of the visit, the plan seeks payment at time of service from the patient of $150.00 and indicates that the remainder will be billed to the patient's insurance.

What the physician's office doesn't know is that in the intervening time between the inquiry and the visit, the insurance company received claims for this patient from a different provider, Provider B, totaling $200.00. As a result of this claim, the patient will have satisfied his/her deductible meaning that the money collected from the patient on the day of the visit represents an overpayment and Provider A must refund the money to the patient.

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

While we continue to support the concept of Health Plan Identifiers, it is not clear that these will substantially improve the current situation. HBMA also encourages NCVHS to encourage the Secretary to mandate that the Plan ID cards contain the relevant beneficiary Identification that will allow the provider to easily access the particular product in which that beneficiary is enrolled.

If the HPID has any hope of ever being of value, it MUST direct the provider – electronically – to the appropriate site the first time with minimal to no work on the part of the provider to "figure out" just what plan the patient is enrolled.

If we are going to move forward with this initiative, not only should the identifiers be standardized, they should also be publicized so that the provider and/or business associate can easily access and identify the numbers required.

Also Health Plans need to do a better job communicating their ID numbers both online and when contacted by phone. Some of HBMA member companies report that many front line Health Plan representatives have no training in EDI and many payers do not handle their EDI transactions directly. Again, it has been the experience of many HBMA member companies that Health Plans use other companies to process their ERAs and EFTs. Examples of these include; PNC Bank, Optum, Emdeon, and CAQH Enroll Hub just to name a few.

With all of the different connections and intermediaries it is not unusual to be transferred numerous times before speaking with someone who can help. Because of this set-up providers are required to manage several different websites for their providers. One company reported that they have between 75-100 log-ins to manage the ERA and EFT setup for their providers.

As Technology evolves, this key data may be available via a number of options including a Web-App, a swipe card, or even the patients smart phone.

On behalf of HBMA I appreciate the opportunity to make these comments and observations and I would be happy to answer any questions you might have.