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Testimony to National Committee on Vital and Health Statistics Subcommittee on Standards

Hearing on Health Plan Identifier

May 3, 2017

Introductory Statement and Change Healthcare Overview

About Change Healthcare

Change Healthcare is one of the largest, independent healthcare technology companies in the United States. We are a key catalyst of a value-based healthcare system – working alongside our customers and partners to accelerate the journey towards improved lives and healthier communities.

We provide software and analytics, network solutions and technology-enabled services that help our customers obtain actionable insights, exchange mission-critical information, control costs, optimize revenue opportunities, increase cash flow and effectively navigate the shift to value-based healthcare.

Our solutions enable improved efficiencies and insights for all major stakeholders across the healthcare system, including commercial and governmental payers, employers, hospitals, physicians and other providers, laboratories and consumers.

While the point of care delivery is the most visible measure of quality and value, we are a healthcare technology solutions company that uniquely champions the improvement of all the points before, after and in-between care episodes.

With our customers and partners, we are creating a stronger, better coordinated, increasingly collaborative, and more efficient healthcare system that enables better patient care, choice and outcomes at scale.

We provide tools and resources designed to empower and deliver significant value to our customers.

- **Payers:** Solutions to address payment accuracy, consumer and member engagement, network management and the transition to value-based payment

- **Providers:** Capabilities to help our customers manage revenue and financial risk, optimize patient access, ensure clinically appropriate care and manage claims and payments across the revenue cycle
- **Consumers:** Digital tools to access personal health information, engage with providers, enable electronic payments and make smart healthcare choices based on quality, cost and convenience

Change Healthcare processes more than 12 billion healthcare transactions and is connected to 5,000 Hospitals, 800,000 physicians, 600 laboratories, 117,000 Dentists and 2,100 payers. This represents $2.0 trillion in healthcare claims and 1 in 5 US Patient records.

Our Commitment

As a company that promotes sensible polices and practical solutions to make healthcare efficient, we support the Secretary's efforts to speed adoption of uniform standards for electronic transactions. It represents a critical step in achieving greater efficiency and cost savings in healthcare.

Change Healthcare is committed to supporting our customers and leading the industry in compliance and adoption of the new transaction standards, operating rules and code sets. We always strive to be prepared in advance of the required deadlines to ensure a smooth and successful transition for our customers.

Change Healthcare is pleased to offer the following comments to the Subcommittee on Health Plan Identifier.

Health Plan Identifier Background Information

Today, billions of health care transactions are exchanged securely and successfully with minimal disruption in the flow using industry standards and a mature ecommerce network. When the need for a national payer identifier was introduced in the 1993 WEDI Report, this was not the case and many transactions were getting lost or misdirected. In the last 25 years, the clearinghouse industry has worked collaboratively to 'fix' the routing issues seen earlier in the development of electronic transactions and to build today's health care ecommerce exchange.

Over the years the health care industry has used the terms "health plan" and "payer" interchangeably, but functionally these two entities have very different roles. To help us better understand the difference between a health plan and a payer, we look to the definitions in both the HIPAA Transactions and Codes Sets Final Rules and the X12 Technical Report for Claims.

X12 Claim Transaction:

For purposes of this standard…The payer is a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government administrator (TPA), repricer, or third party administrator (TPA), repricer, or third party organization (TPO) that may be contracted by one of those groups. [1]

Regulation:

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)). Health plan includes, when applied to government funded programs, the components of the government agency administering the program. Health plan includes the following, singly or in combination:

(1) A group health plan, as defined in this section.
(2) A health insurance issuer, as defined in this section.
(3) An HMO, as defined in this section.
(4) Part A or Part B of the Medicare program under title XVIII of the Act.
(5) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396 et seq.
(6) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).
(7) An issuer of a long-term care policy, excluding a nursing home fixed indemnity policy.

[1] ASC X12 Health Care Claim: Professional (837) 00501X222, February 2011 Section 1.4 Business Usage

(8) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
(9) The health care program for active military personnel under title 10 of the United States Code.
(10) The veteran's health care program under 38 U.S.C. chapter 17.
(11) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 U.S.C. 1072(4).
(12) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
(13) The Federal Employees Health Benefit Program under 5 U.S.C. 8902 et seq.
(14) An approved State child health plan under title XXI of the Act, providing benefits that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397 et seq.
(15) The Medicare + Choice program under part C of title XVIII of the Act, 42 U.S.C. 1395w–21 through 1395w–28.
(16) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg–91(a)(2)) [2]

The relationship between a payer and health plans is complex and hinges on the functions performed. In some cases, when an employer is a large company, the "health plan" may be self-funded and contracts with a "payer" to administer the benefits. The "payer" may change from year to year, but the health plan remains the same. In other cases, when an employer is a small company, the "payer" may provide the wholly funded "health plan" as well as the administration of the benefits. Conversely, a large commercial payer may administer benefits for many self-funded, partially funded, or wholly insured health plans. Many also provide administrative services for government health plans as well.

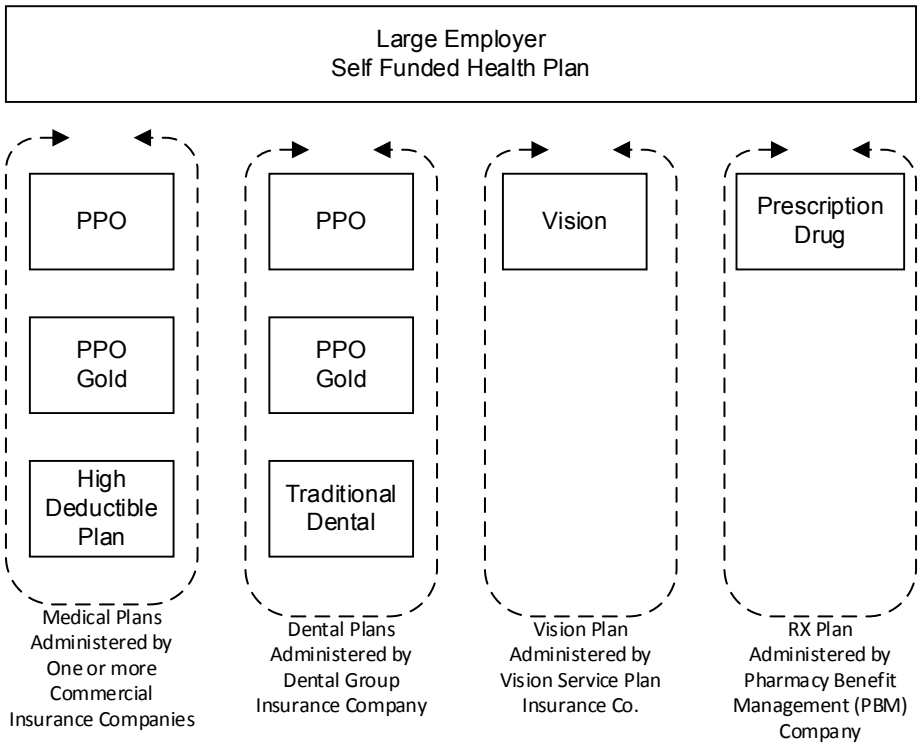
There are many variations of these two use cases, but the key difference is who actually provides the administrative functions. That entity is the one engaged in the exchange of the HIPAA standard transactions.

[2] 45 CFR Parts 160 and 162 Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice

In Figure 1, the administrative transactions mandated under HIPAA are exchanged electronically between the health care provider and the administrators (payers) of the benefit plans. In this case, the Commercial Insurance Company, Dental Group Insurance Company, Vision Service Plan or the Pharmacy Benefit Management Company are the administrators. The Health Plan never sees the transaction and is not acknowledged in the transaction. The transactions are routed to the payer (administrator) using established payer identifiers. Each administrator would have their own payer ID.

The use of HPID gets complex in this scenario – is it the HPID of the Large Employer, the PPO plan, Vision plan or dental plan that is reported? It is not clear in the current regulation as to which would be used.

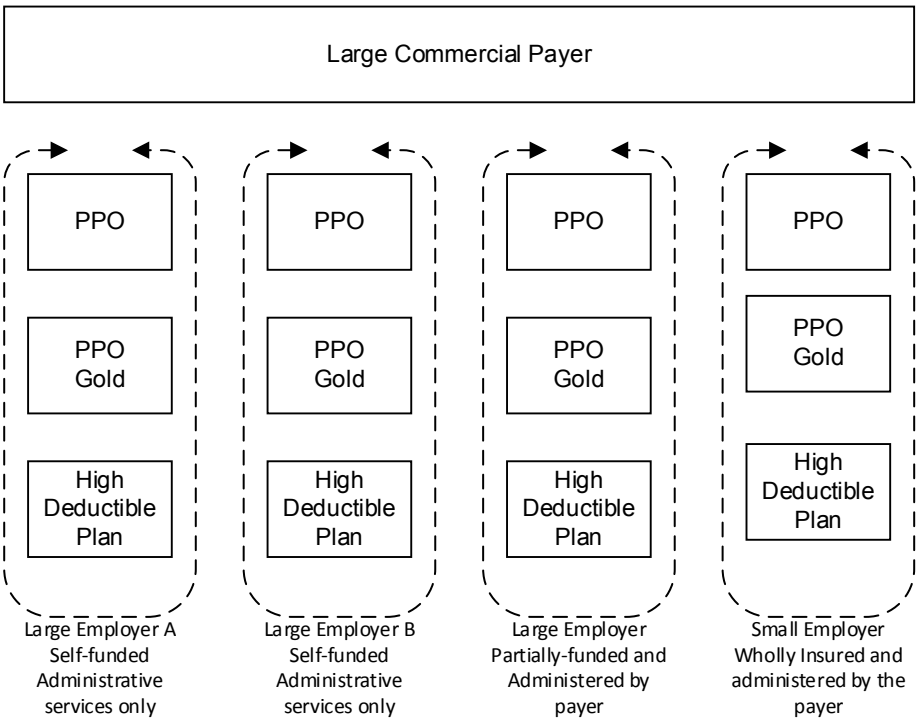
Figure 1: Large Self-Funded Health Plan



In Figure 2 the large commercial payer (identified by established payer ID) is the administrator for many large self-funded, partially funded, and wholly insured health plans. As in the previous diagram, the Health Plans never see the transactions and are not acknowledged in the transaction. The transactions are routed to the payer (administrator) using established payer identifiers.

The use of HPID is just as complex in this scenario – is it the HPID of the Large Employer, the PPO plan, Vision plan or dental plan that is reported? It is not clear in the current regulation as to which would be used.

Figure 2: Large Commercial Payer



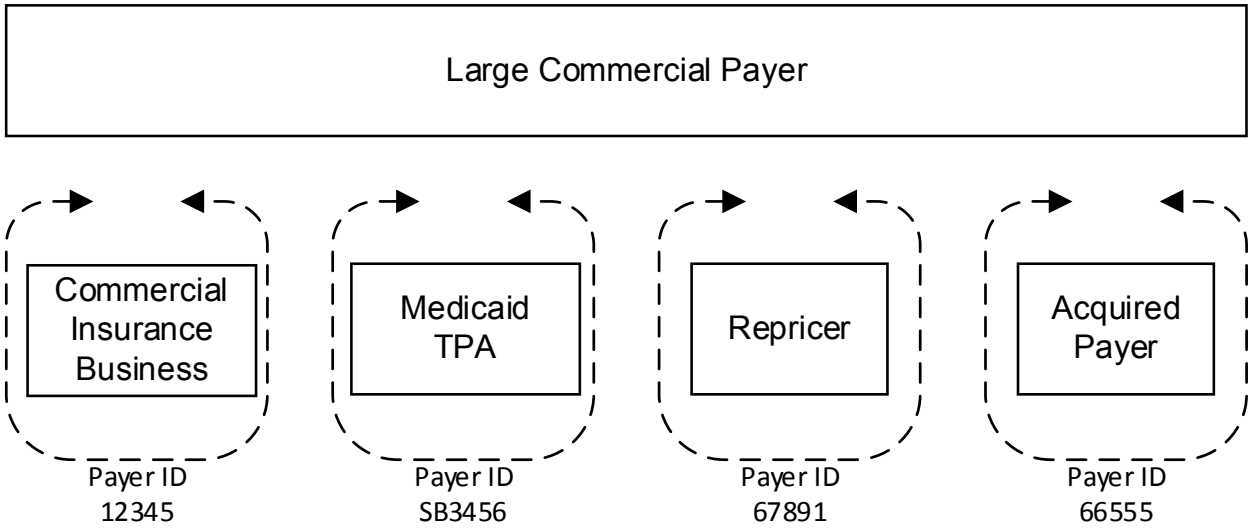
On Figure 3, represents the situation when a payer may have more than one payer ID. At times there are valid reasons for a payer to request multiple identifiers to help with their internal routing and business needs. One case is when a payer acts as the administrator for multiple product lines of business. For example, a payer may act as an administer for commercial health insurance as well as a third party administrator for Medicaid or another type of insurance.

Payers may contract with provider networks to negotiate allowable amounts for services rendered within the network. There are various ways that the 'repricing' of a claim is done. In some cases, the repricer receives the claim directly from the provider requiring the use of a separate payer identifier for the repricer; or the provider may send the claim to a clearinghouse, which will route claims requiring repricing to the appropriate PPO, the PPO will then return the

repriced claim to the clearinghouse, which will then route the repriced claim to the destination payer; in another scenario the payer receives the claim and reroutes to the repricer; or the payer may reprice the claim themselves. In all cases, Payer identifiers are utilized to accurately route claims to the appropriate receiver.

Sometimes a payer acquires another payer and may continue to use separate payer identifiers for some period of time while consolidation and notification to providers is complete or the payer chooses to continue to utilize the acquired and established payer identifiers. In today's environment the payer and/or the clearinghouse notifies the providers of Payer ID changes as they occur and provider products are routinely updated as appropriate.

Figure 3: Payer with Multiple Payer IDs



Questions posed by the Committee

We provide the following insights and responses to the questions posed to us.

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

   In today's environment, health plan identifiers are not used to identify a payer. In some transactions, the Group Plan Name or Group Number is exchanged and is associated with the patient/subscriber.

   The Payer ID is used for many administrative functions and is commonly based off of the National Association of Insurance Commissioners (NAIC) Number or a proprietary number assigned by the payer or receiving entity and is typically a 5-byte alpha-numeric identifier. Some examples of the use of Payer ID are:

   - Payer Specific Edits - Payer requirements for such things as the appropriate formatting of the patient identifier.
   - Payer Look Up – The ability to look up the appropriate identifier and/or billing address to ensure proper distribution.
   - Payer Lists – used by customers to determine levels of participation for payers and to obtain payer identifiers.
   - Provider Enrollment - Verification that the provider has been 'approved' by the payer to submit transactions electronically. Significant use for Medicare and Medicaid transactions.
   - Payer Format - Appropriate formatting of the transaction including trading partner specific information included in the 'envelope'.
   - Aggregation – The ability to batch and aggregate transactions for distribution.
   - Distribution - Distribution of the transactions to the appropriate receiver such as payers, repricers or another clearinghouse based on defined distribution schedules.
   - Re-Routing – in some instances the payer identifier allows the clearinghouse to re-route the transactions to repricers.
   - Report distribution – reports are received from the payer and parsed for distribution to the multiple providers identified in the report.
   - Billing of transactions – Some billing systems may use the payer identifier to determine the costs to the payer.

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

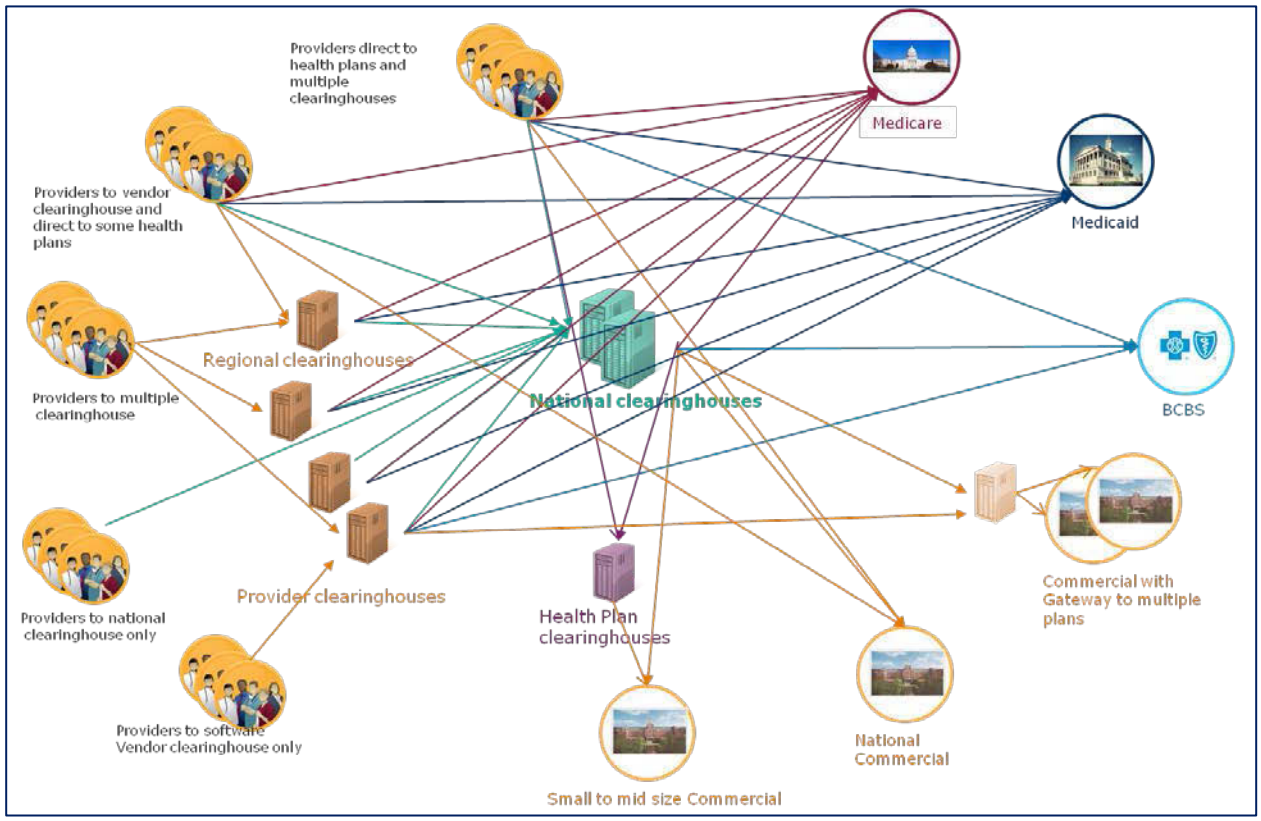
   At this time, there is no clear business need or use for the HPID as defined in the regulation. The current Payer ID in use today supports the business needs of health care administrative ecommerce.

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?***

   As currently established, we see no benefit to the HPID model and it does not meet our business need for the editing and routing administrative transactions.

4. ***What challenges do you see with the current HPID model established by HHS?***
   There are many different kinds of entities that participate in healthcare transactions as shown in Figure 4 (i.e., providers, regional/national clearinghouses, government/commercial payer). Today, a health plan identifier is not used for exchanging administrative transactions. Instead, a 'payer' identifier is used for many different functions.

Figure 4: Health Care EDI Network



Given the complex environment, and the current use of Payer IDs within established administrative transaction workflows, it is clear that if any given stakeholder were to move to HPIDs in the place of payer IDs, it would have ripple effects throughout the system – all the immediate trading partners as well as other entities further upstream and downstream would need to update their databases, applications, interfaces, and workflow processes.

Impact to Healthcare Management Systems

Many healthcare management systems (i.e., physician, hospital, dental) contain a built-in list of payers for the provider to select as appropriate for the patient. It is typical for the payer selection to populate the corresponding payer identification number when generating an electronic transaction. The number is not associated with the Health Plan but rather with the entity responsible for administering the benefits and payments on behalf of the Health Plan.

In today's environment, the payer identifier is commonly based off of the National Association of Insurance Commissioners (NAIC) Number or a proprietary number assigned by the receiving entity and is typically a 5-byte identifier.

In addition to the sizing implications, (current 5-byte payer ID vs. 10-byte HPID) depending on the extent of the enumeration granularity, the change would require a new table lookup for the providers to select the appropriate payer for the health plan and also determine the appropriate routing of the transaction for administration purposes.

When a provider utilizes the services of one or more clearinghouses to distribute their transactions, the clearinghouse would also need to associate the health plan with a payer in order to insure the proper routing of the transactions. Many providers use a variety of methods for submitting their transactions – some direct and some through one or more clearinghouses. Each entity that touches the claim would need to be able to match the health plan with the appropriate payer. If not done properly the flow of transactions can be disrupted causing a negative impact to cash flow and risk of PHI breaches.

Since health plans frequently change administrators of their benefits, the on-going maintenance required to establish the relationship between a health plan and payer will place a huge burden on the entire healthcare industry.

Most health care management software vendors have built in edits to support specific requirements based on the payer. These edits are often driven off of the payer ID and each edit would need to be modified to account for perhaps many HPIDs enumerated by the payer. Depending on the vendor, this may require redeployment of the

software.

Impact to Clearinghouse Services

Once the transaction is received by a clearinghouse, rules are performed to provide value-added services to both the provider and payer. In many cases, the provider will be notified in a relatively short time (in many cases the same day) of errors based on global and payer specific rules and payers have expectations of receiving 'clean claims'.

Each process in the clearinghouse that utilizes the payer ID (see Question 1) would require remediation to support the more complex and granular HPID. Clearinghouses would be expected to provide a complex look-up or crosswalk solution to association the health plans with the appropriate payers to simply route transactions. Since transaction routing is already successfully in place today with little issue, the massive effort and the cost to maintain would result in no return on the investment. The estimated cost for Change Healthcare to transition from payer ID to HPID was over $11,000,000.

Routing/Misrouting of Transactions

The health care industry has a large, complex network for routing transactions much like our National Interstate Highway. The ecommerce 'route' can be as simple as going direct from provider to payer or can involve one clearinghouse (provider to clearinghouse to payer). The ecommerce route can be more complex and involve multiple clearinghouses. When the route has clear directions it makes it easy to get from point A to point B. But sometimes the route is not a straight line and requires using multiple exits and entries points. If the wrong "route number" is used, then misrouting occurs.

Following the highway analogy, if all of a sudden the route numbers changed how many people would get lost and what would be impacted (i.e., GPS and Navigation Systems, written instructions, or on-line directions)?

The same is true with the ecommerce network if the Payer ID (route number) were to change. Transaction could get lost or misrouted. There would also be increased risk of protected health information (PHI) violations as the migration from one identifier to another occurs and continued on-going maintenance as a health plan may switch payer administrators without the knowledge of the provider or other stakeholders resulting in PHI being routed to the wrong destination.

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

Clarification of business use for HPID

Our recommendation would be to repeal the current regulation for HPID until such time as the industry provides a clear business use case, implementation and operational costs, and expected ROI for all stakeholders and entities.

Use in Standard Transactions

We also recommend that HPID in transaction standards be removed until a clear business use can be presented to the standards development organizations. Currently, the transactions have replaced the primary payer ID with the HPID and associate the HPID with a payer. We recommend that this be changed before the next version is adopted to an associate the HPID, when used, with the patient/subscriber. As previously stated, the Health Plan of a patient can remain the same with the payer changing from one year to the next and payers support many health plans.

Closing

The cost, risk, and overall impact to all industry stakeholders is significant when proposing changes to the established Payer ID and would result in no additional functionality or return on investment. If the regulation is not revised to remove the requirement for use in transactions the cost and impact to the industry will be significant. We strongly recommend that a full cost / benefit analysis be completed as an aspect of justification.

We support the enumeration of health plans at the appropriate level deemed necessary **if** there is a business case to support this, however, we strongly recommend removing the use of the HPID/OEID within health care transaction standards.

Change Healthcare appreciates the opportunity to provide comments to the Subcommittee on the current HPID regulation. Should you have any questions, or wish to discuss our comments further, please do not hesitate to contact me.

Respectfully,
Deborah Meisner
Vice President of Regulatory Compliance

CHANGE HEALTHCARE

03.02.2017

Change Healthcare

For use in previously scheduled meetings with existing prospects/customers

CHANGE HEALTHCARE™

On March 2, 2017, we announced the closing of our transaction and created a new healthcare technology company

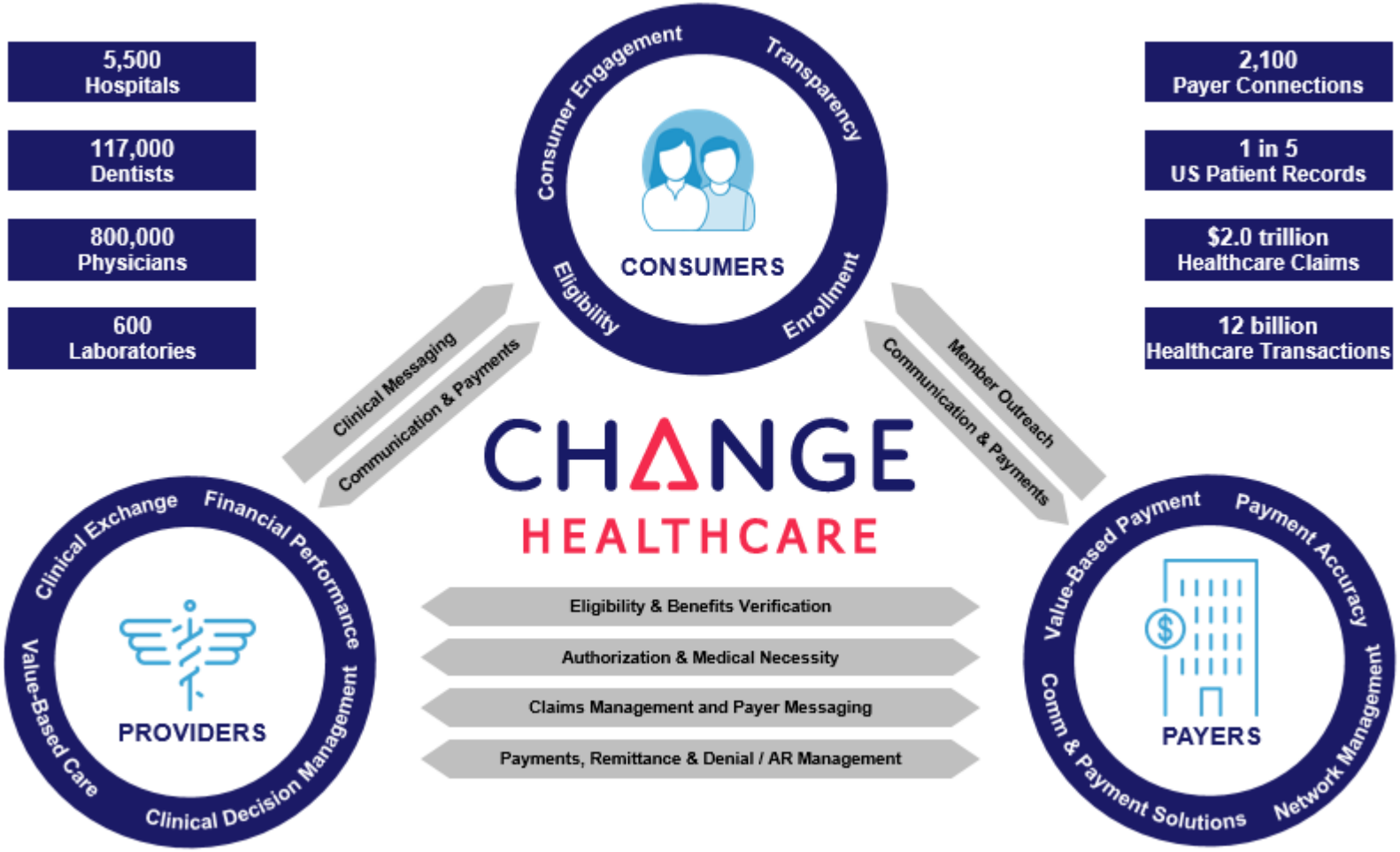
The new Change Healthcare brings together the complementary strengths of McKesson Technology Solutions (MTS) and Change Healthcare to deliver a broad portfolio of solutions to help:

- Lower healthcare costs
- Improve patient access and outcomes
- Manage the transition to value-based care

CHANGE HEALTHCARE

With our customers and partners, we are creating a stronger, better coordinated, increasingly collaborative and more efficient healthcare system that enables better patient care, choice and outcomes at scale.

The new Change Healthcare: a well-positioned leader



Health Plan Identifier Background

WHY?

- 1993 WEDI Report
    - Need for a National Payer Identifier
    - Transactions were getting lost or misdirected
- 24 years later – the industry has worked collaboratively to ‘fix’ the problem
- Today billions of transactions are exchanged with minimal disruption in the flow

Health Plan vs. Payer

- Used interchangeably but functionality is different

Regulation

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)). Health plan includes, when applied to government funded programs, the components of the government agency administering the program. Health plan includes the following, singly or in combination:

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X12 Claim Transaction

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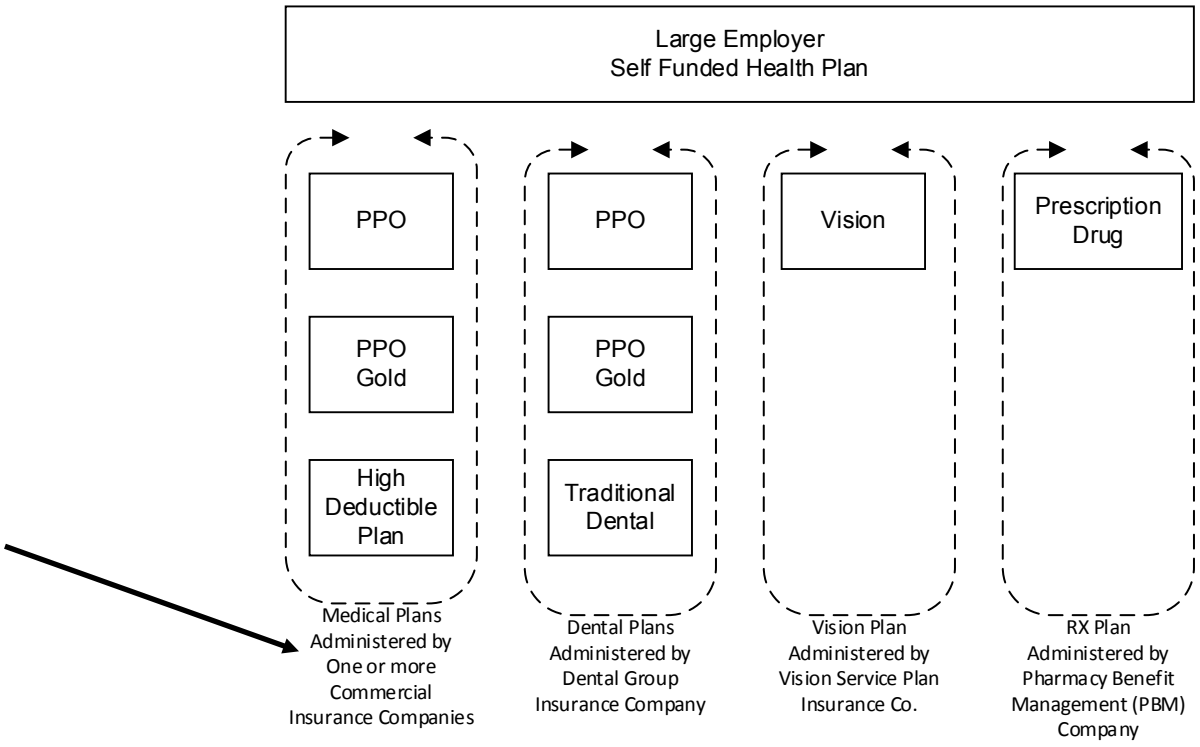
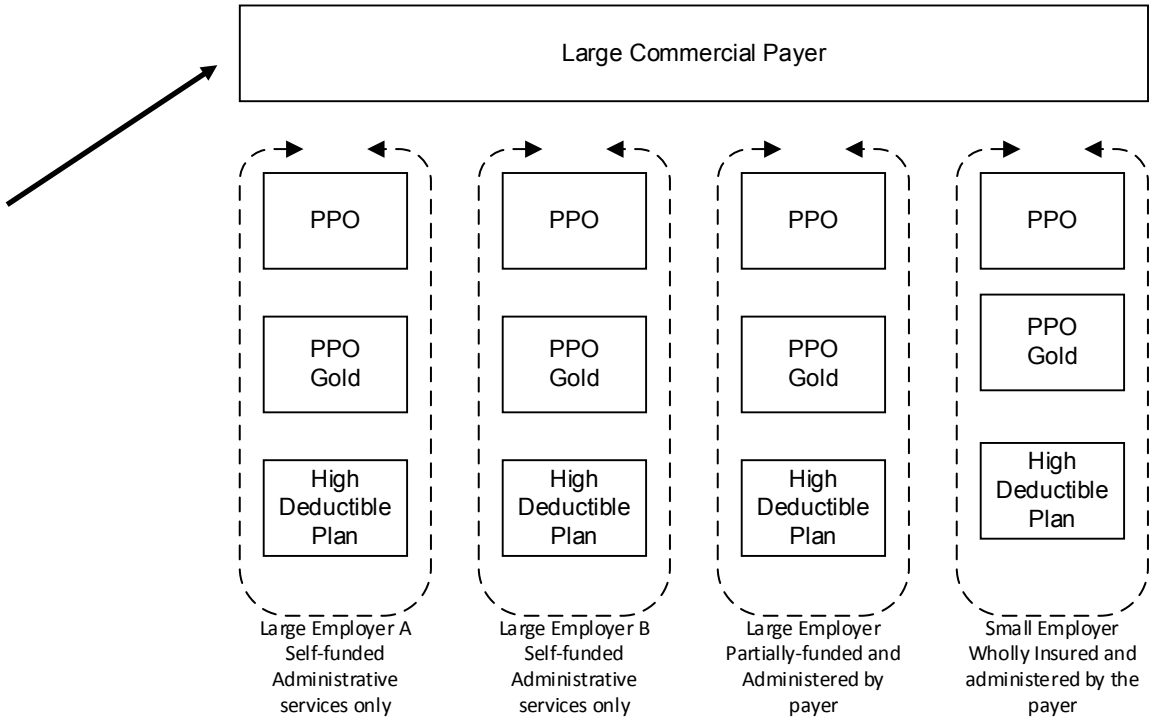
[1] ASC X12 Health Care Claim: Professional (837) 00501X222, February 2011 Section 1.4 Business Usage

Large Self-Funded Health Plan Example



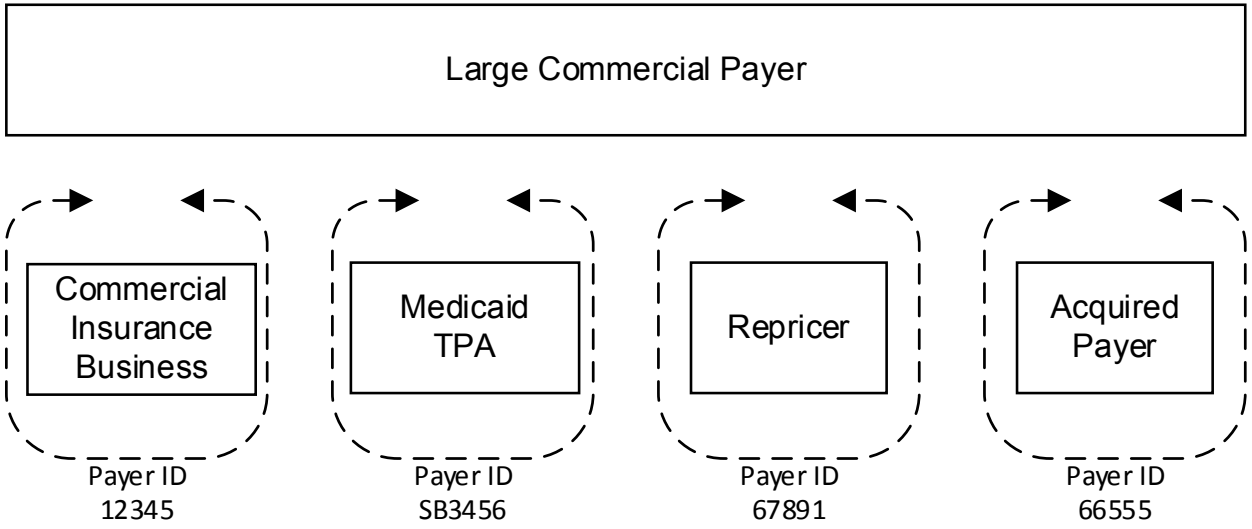
Administrative transactions mandated under HIPAA are exchanged between the health care provider and the administrators of the benefit plans. In this case, Commercial Insurance Company, Dental Group Insurance Company, Vision Service Plan or the Pharmacy Benefit Management Company. **The Health Plan never sees the transaction and is not acknowledged in the transaction.** The transactions are routed to the payer (administrator) using the legacy payer identifiers. Each administrator would have their own payer ID.

Large Commercial Payer Example



The large commercial payer (identified by legacy payer ID) is the administrator for many large self-funded, partially funded and wholly insured health plans. As in the previous diagram, **the Health Plans never see the transactions** and is not acknowledged in the transaction. The transactions are routed to the payer (administrator) using the legacy payer identifiers.

Payer with Multiple Payer IDs



1. Payer acts as the administrator for multiple product lines of business.
2. Payer acquires another payer and may continue to use separate payer identifiers for some period of time while consolidation and notification to providers is complete or the payer chooses to continue to utilize the acquired and established payer identifiers
3. Payer uses a Repricer

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

In today's environment, health plan identifiers are **not used** to identify a payer. In some transactions, the Group Plan Name or Group Number is exchanged and is associated with the patient/subscriber.

The **Payer ID** is used for many administrative functions and is commonly based off of the National Association of Insurance Commissioners (NAIC) Number or a proprietary number assigned by the payer or receiving entity and is typically a 5-byte alpha-numeric identifier.

Examples of Payer ID Use

- Payer Specific Edits - Payer requirements for such things as the appropriate formatting of the patient identifier.
- Payer Look Up – The ability to look up the appropriate identifier and/or billing address to ensure proper distribution.
- Payer Lists – used by customers to determine levels of participation for payers and to obtain payer identifiers.
- Provider Enrollment - Verification that the provider has been 'approved' by the payer to submit transactions electronically. Significant use for Medicare and Medicaid transactions.
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- Billing of transactions – Some billing systems may use the payer identifier to determine the costs to the payer.

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

At this time, there is no clear business need or use for the HPID as defined in the regulation. The current Payer ID in use today supports the business needs of health care administrative ecommerce.

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?

As currently established, we see no benefit to the HPID model and does not meet our business need for editing and routing administrative transactions.

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

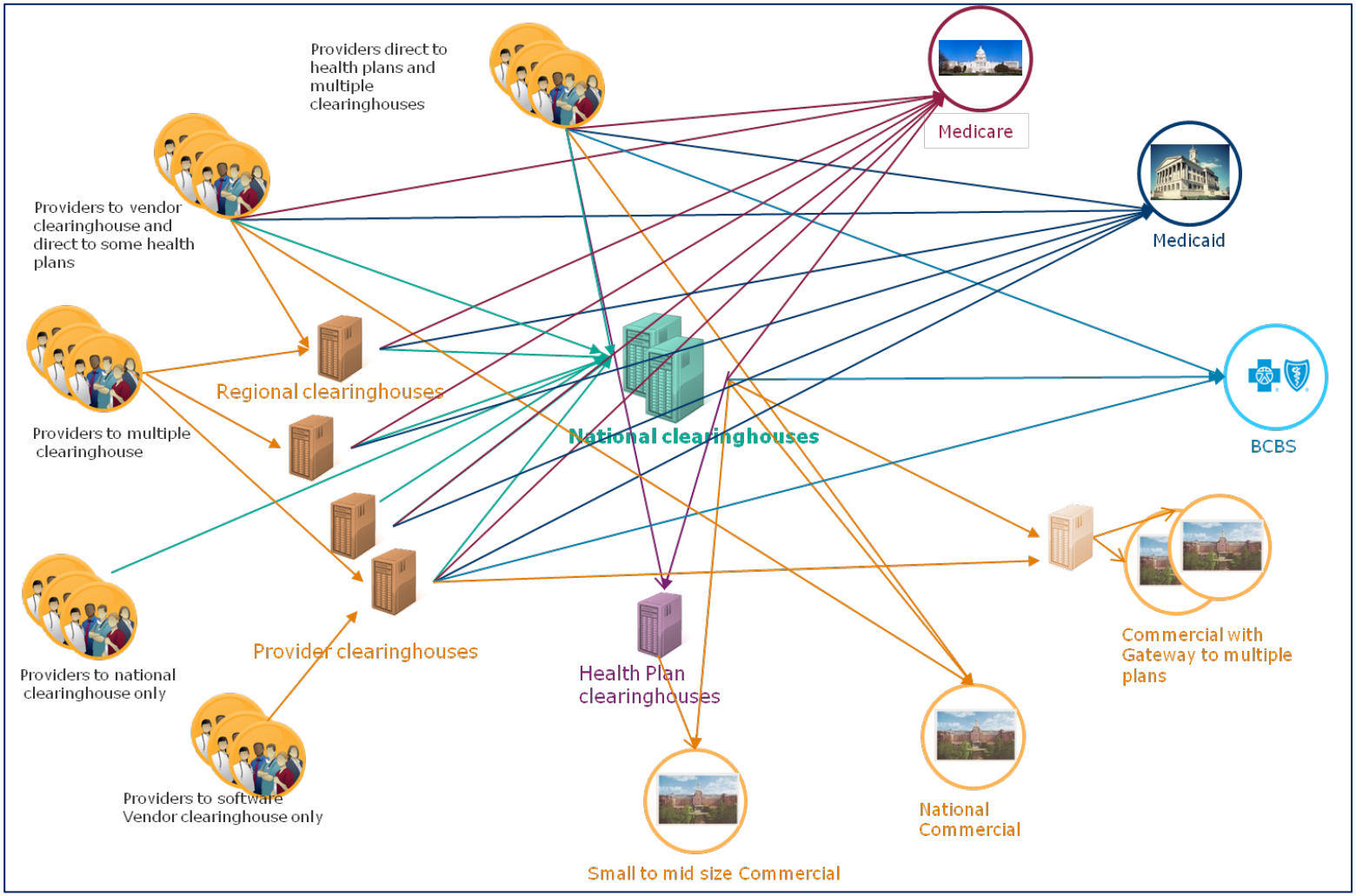
Today, a health plan identifier is not used for exchanging administrative transactions. Instead, a 'payer' identifier is used for many different functions.

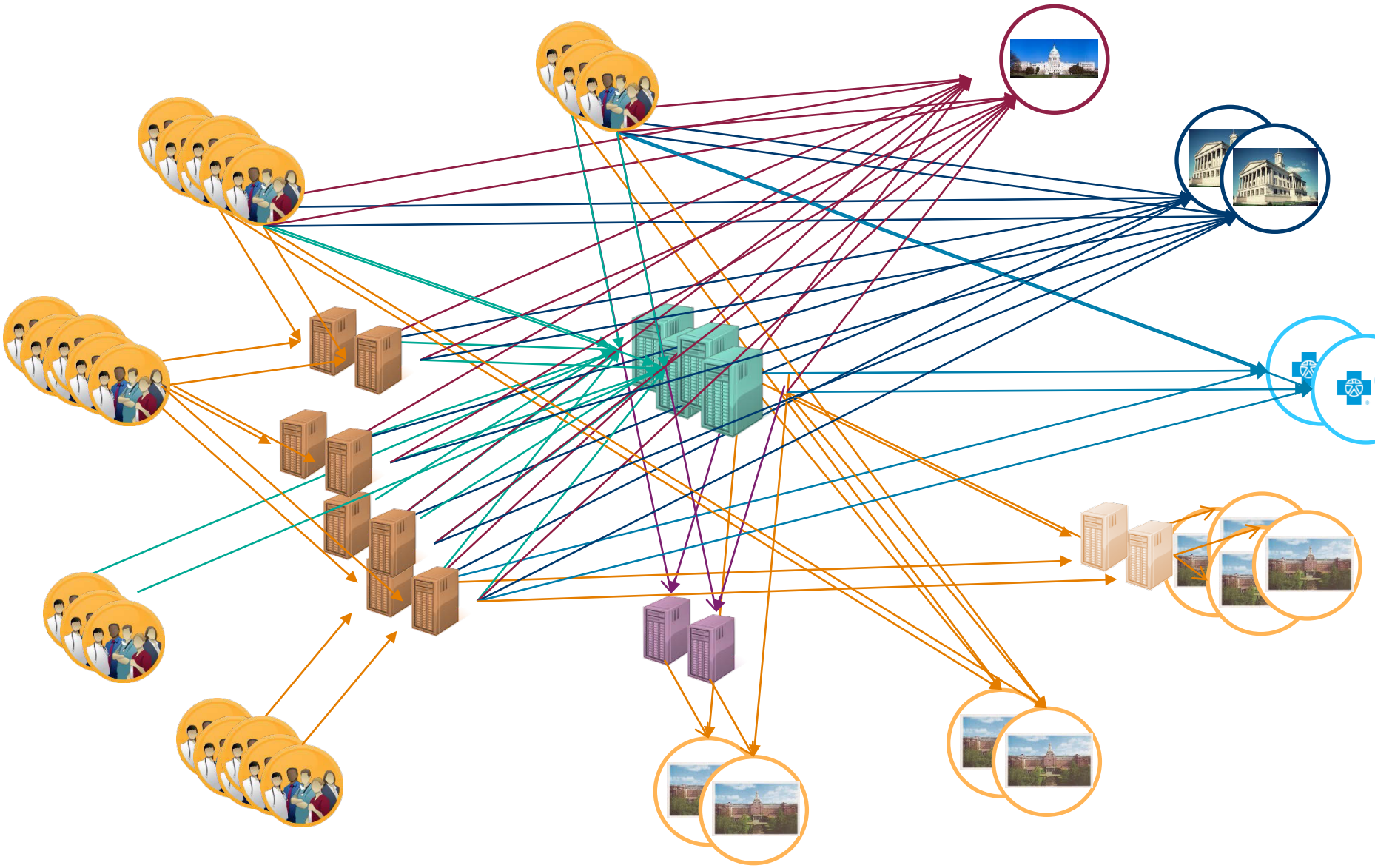
Given the complex environment, and the proliferation of partner–specific, non-standard legacy Payer IDs, it is clear that if any given stakeholder were to move to HPID in the place of payer IDs, it would have ripple effects throughout the system – all the immediate trading partners as well as other entities further upstream and downstream would need to update their databases, applications, interfaces, and processes.

Routing/Misrouting

- Health care industry has a huge network for routing transactions much like our National Interstate Highway
- The network can be simple from provider to payer
- The network can involve one clearinghouse so from provider to clearinghouse to payer
- Or the network can involve multiple clearinghouses
- When you have clear directions this is fairly simple
- Sometimes routing is not a straight line and requires using multiple exits and entries
- If the wrong “route number” is used then misrouting occurs.

Health Care Network Today





The Payer ID is the Route Number used in effectively exchanging healthcare transactions

- If you looked at the highway analogy and all of a sudden the Route numbers changed think of how many people would get lost
- Think of what would be impacted
  - GPS Systems
  - Navigation Systems
  - Written instructions
  - Directions on Websites

- The same is true in the EDI Network if the Payer ID were to change.
  - PHI is at risk
  - Additional cost in reworking
  - Cash flow is impacted.

Closing

The cost, risk, and overall impact to all industry stakeholders is significant when proposing changes to the established Payer ID and would result in no additional functionality or return on investment. If the regulation is not revised to remove the requirement for use in transactions the cost and impact to the industry will be significant. We strongly recommend that a full cost / benefit analysis be completed as an aspect of justification. The estimated cost to Change Healthcare alone was $11 million with no ROI.

We support the enumeration of health plans at the appropriate level deemed necessary **if** there is a business case to support this, however, we strongly recommend removing the use of the HPID/OEID within health care transaction standards

Thank You

Change Healthcare appreciates the opportunity to provide comments to the Subcommittee on the current HPID regulation. Should you have any questions, or wish to discuss our comments further, please do not hesitate to contact me.