



National Committee on Vital and Health Statistics

June 21, 2017

The Honorable Thomas E. Price, M.D.
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Findings and Recommendations from the May 3, 2017 NCVHS Standards Subcommittee Hearing on the Health Plan Identifier

Dear Secretary Price:

This letter conveys a set of recommendations from the National Committee on Vital and Health Statistics (NCVHS) regarding the Health Plan Identifier (HPID).

NCVHS is your advisory committee on health data, statistics, privacy, and national health information policy. NCVHS advises the Secretary on the adoption of standards, unique identifiers and code sets under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as the Patient Protection and Affordable Care Act (ACA) of 2010, which calls for NCVHS to assist in the achievement of administrative simplification to “reduce the clerical burden on patients, health care providers, and health plans.”

Each year, NCVHS holds industry hearings on standards, code sets, identifiers and operating rules adopted under HIPAA and ACA to evaluate the need for updates and improvements. This letter represents the findings from our May 3, 2017 hearing.

Health Plan Identifier (HPID)

A unique health plan identifier was originally called for under HIPAA. ACA subsequently required the Secretary to adopt the unique health plan identifier based on input from NCVHS.

Beginning in 2010, NCVHS held several hearings on this topic in order to solicit industry feedback. Based on our findings, NCVHS issued letters to the Secretary outlining our observations and recommendations for revision or improvement¹.

On September 5, 2012, HHS published a final rule on the unique health plan identifier (HPID). The HPID final rule had two independent and separate categories of requirements: 1) enumeration and 2) use of the HPID in HIPAA transactions. The final rule also adopted an Other Entity Identifier (OEID). The OEID was intended to function as a voluntary identifier for entities that were not health plans, health care providers, or individuals, but would need to be identified in HIPAA standard transactions.

¹ NCVHS letters dated September 30, 2010, May 15, 2014 and September 23, 2014 are attached.

In 2014, NCVHS began to hear a growing concern from health care stakeholders about the HPID policy. In February 2014 and June 2014, NCVHS held public hearings to evaluate these ongoing concerns. As noted in the September 23, 2014 recommendation letter to the Secretary, stakeholders reported they would obtain no benefit or value by using HPIDs in health care transactions. Specifically, the transaction routing problem that HIPAA sought to resolve had subsequently been resolved by private industry's voluntary adoption of a standardized payer identifier ("Payer ID"), based on the National Association of Insurance Commissioners (NAIC) identifier, as described in that letter.

Testifiers concurred that the HPID should not be required for use in transactions and that it should not replace the Payer ID. As a result, on October 31, 2014, HHS announced a delay, until further notice, in the enforcement of the regulation pertaining to health plan enumeration and use of the HPID in HIPAA transactions adopted in the HPID final rule.

The most recent testimony provided at the May 3, 2017 NCVHS Standards Subcommittee hearing was consistent with prior input, and the findings that were provided in our September 23, 2014 NCVHS letter to your predecessor. The feedback overwhelmingly affirmed that there is no longer an industry need for the HPID in the HIPAA standard transaction sets.

Testifiers were unanimous that the Payer ID, which is currently used as the identifier within standard electronic transactions, is sufficient for the routing needs for those transactions. Testifiers concurred again that the transaction routing challenges of two decades ago have been resolved by the industry and that implementation of the HPID would be disruptive, costly, and counterproductive to administrative simplification. Testifiers were strong in their belief that the HPID provides no value as a health plan identifier within standard transactions since routing is performed at the payer level. Testifiers further explained that health care standard transactions are predicated on business flows that relate to payers and administrative entities as well as health plans².

Potential Other Uses for the Health Plan Identifier

The primary objective in the HHS 2012 Final Rule for adopting a health plan identifier was to create a standardized data element for use within the HIPAA standard transactions. However, HHS also referenced potential secondary uses, i.e., other lawful uses such as for the identification of health plans in the federal and state insurance exchanges and for the health plan certification requirement established in the Patient Protection and Affordable Care Act.

As industry needs or policy objectives become clearer, NCVHS may consider non-transaction applications of a health plan identifier for consideration in its future work plans.

After due deliberation, NCVHS recommends the following:

Recommendation 1: HHS should rescind its September 5, 2012 HPID Final Rule which required health plans to obtain and use the HPID.

² On July 21, 2014, the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) HPID Workgroup, published an issue brief to aid the industry in understanding the difference between the terms "health plan" and "payer" is attached.

Recommendation 2: HHS should communicate its intent to rescind the HPID Final Rule to all affected industry stakeholders as soon as a decision is made. HHS should provide the applicable guidance on the effect a rescission may have on all parties involved.

Recommendation 3: HHS should continue with the 2014 HPID Enforcement Discretion until publication of the regulation rescinding the September 5, 2012 HPID Final Rule.

Thank you for considering the recommendations outlined in this letter. NCVHS remains available to answer questions and will continue to support HHS efforts to advance efficiencies in the health care system, and to working with the Department to shape future guidance.

Sincerely,

/s/

William Stead, MD, Chair

National Committee on Vital and Health Statistics

Attachments (4)

NCVHS Letter to the Secretary September 30, 2010

NCVHS Letter to the Secretary May 15, 2014

NCVHS Letter to the Secretary September 23, 2014

WEDI SNIP HPID Workgroup Issue Brief

Cc: HHS Data Council Co-Chairs



September 30, 2010

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

Re: Affordable Care Act (ACA), Administrative Simplification: Health Plan Identifier

The National Committee on Vital and Health Statistics is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010, calls for the Secretary to promulgate a final rule to establish a unique health plan identifier (HPID) based on the input of NCVHS.

A unique national plan identifier was originally called for under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subtitle F—Administrative Simplification. The purpose of the original Administrative Simplification provisions was to “improve the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.” These provisions included requirements for the adoption of standards for transactions and code sets and standard unique identifiers for individuals, employers, health plans, and health care providers. To date, federal regulations have been issued to address the transactions and code sets, and to adopt a national standard unique identifier for employers and for health care providers. Regulations for a standard unique identifier for health plans have not yet been adopted.

To understand the issues associated with an HPID, NCVHS contracted for an environmental scan to be conducted (see Appendix A for the Environmental Scan, also available at www.ncvhs.hhs.gov) and held hearings on July 19-21, 2010. A wide range of stakeholders provided in-person or written testimony,

including health plans, provider organizations, health care clearinghouses, pharmacy industry representatives, standards developers, professional associations, representatives of Federal and State public programs, the Workgroup on Electronic Data Interchange (WEDI), and individuals with specific HPID proposals. Testifiers described a number of key characteristics, features, uses and needs for an HPID, including being able to correctly route transactions; reduce the cost of managing financial and administrative information; improve the accuracy and timeliness of claims payment; and reduce dissatisfaction among providers and patients/members by improving communications with health plans and their intermediaries. While testifiers described their needs from different perspectives, all who stand to be impacted by the HPID observed it is important to ensure that the new identifier can be used in existing standard transactions. There was also consensus that the enumeration, maintenance, and use of the HPID be kept simple, but robust enough to achieve the desired impact and ensure a smooth transition.

Pertinent to the discussion of a unique health plan identifier is the definition of “health plan.” The original HIPAA legislation (P.L. 104-191) and subsequent regulations (45 CFR Part 160.103) provide a definition for health plan. That definition includes references to entities responsible for payment of claims for health care services and to policies or contracts between an entity and individual specifying benefit coverage. In the context of health plan enumeration, this range exemplifies the multiplicity of purposes for health plan enumeration. At the most basic level, a provider needs to be able to identify the entity that should receive queries about an individual’s eligibility for coverage, and the entity to which a request for payment should be sent; in other words, the entities that must be identified in a standard eligibility or claim transaction.

However, actual practice shows that health plans come in a variety of types, forms and arrangements through which they perform and deliver their services. These include health plan components that represent varying lines of business or market segments such as medical, dental, property and casualty; types of products or categories of insurance programs such as PPO, HMO, indemnity, Medicare Advantage, Medicaid; specific products such as PPO Gold or Medicare Supplemental products; and group plans or contracts specific to a group. The above listing is provided for illustrative purposes and does not constitute the whole, or even a recommended taxonomy on what is to be enumerated. There is no gold standard definition for a health plan that can guide an enumeration process—and who or what needs to be numbered.

In today’s market, a variety of administrative and processing intermediaries assist in the performance of financial and administrative transactions. These include, for example, rental networks that provide access to defined provider networks; benefits managers; third party administrative service providers, repricers and others. These intermediaries may not be health plans in the traditional sense, but they have evolved to fulfill roles of a health plan, and are relevant to the content and transmission of HIPAA transactions. These entities often need to be identified in the transaction for successful, efficient communication. Enumeration of these entities is important as they may be the actual

recipients of provider queries or claims rather than the health insurance issuer or other entity ultimately responsible for payment.

The committee recognized that there are many other implications for a health plan identifier. For example, on a more complex level than described above for standard transactions, purchasers of health insurance may wish to monitor the performance of the issuers of products and policies using a unique identifier for those entities. Such monitoring, though not accomplished through the use of the HIPAA standard transactions, may be achieved in other ways using an identifier. The information might be analyzed by employers, public programs a health insurance exchange or by insurance commissioners.

With respect to its charge in the ACA, and based on the testimony (see Appendix B for list of testifiers and commenters), NCVHS has developed a set of nine observations and recommendations as input to the Secretary for adopting a standard national unique HPID. Observations and recommendations are provided on (1) definitions and entities eligible for enumeration with an HPID , (2) levels of enumeration, (3) the format and content of the HPID, (4) the directory database to support the HPID, (5) the pharmacy industry use of the HPID, (6) the implementation process and timing, (7) applicable testing of the HPID enumeration process, (8) use of the HPID on a health plan identification card, and (9) improving the use of standards and operating rules in support of HPID purposes:

1. **Observations for definitions and types of entities eligible for enumeration with an HPID:** While testifiers urged simplicity in the identifier, there was also urgency for assuring that appropriate products be enumerated such that applicable communications could be facilitated. In other words, a health plan may have one or more HPIDs – one for itself, and one for each of its products. Intermediaries would also be able to obtain their own HPID.

Recommendations – HHS should:

- 1.1 clarify the definition of health plan as specified in the HIPAA regulations (45 CFR Part 160.103) for purposes of HPID eligibility and enumeration, including that property and casualty insurers and workers' compensation plans could be eligible for such enumeration even though they are not covered entities.
- 1.2 work with stakeholders to reach consensus on names and definitions for intermediary entities. Consider making these intermediary entities eligible to obtain an HPID where there is a clear use case for them to be enumerated.
- 1.3 request stakeholder input through groups such as Workgroup on Electronic Data Interchange (WEDI), America's Health Insurance Plans (AHIP), National Association of Insurance Commissioners (NAIC), and the Designated Standards Maintenance Organizations (DSMO) Committee for definitions of

products to be used in plan enumeration by October 31, 2010 (or other date as feasible by CMS).

- 1.4 collaborate across Federal agencies and departments to develop or identify consensus definitions affecting the identification of health plans, including Indian Health Service (IHS), Department of Veterans Affairs (VA), Department of Defense (DoD), and the Federal Employee Health Benefit Program (FEHBP).
 - 1.5 coordinate, to the maximum extent feasible, the development and implementation of the HPID with other plan related requirements in the Affordable Care Act, including, for example, the consumer health insurance web portal, the health insurance exchanges and the regulatory requirements for health plans.
2. **Observations relating to levels of entity enumeration:** The NCVHS observes that the HPID should fulfill the original intent of HIPAA to improve the efficiency of the health care system by adopting standards for electronic exchange of health information. As such, the HPID enumeration process needs to ensure that the right entities (including at least the transaction recipient, administrator, and financially responsible party) are enumerated. Several years ago, CMS defined the National Payer ID, pre-HIPAA, as “a system for uniquely identifying all organizations that pay for health care services;” noting this was also known as Heath Plan ID, or Plan ID. At that time, there was much discussion about the value of using plan product information, such as the levels of indemnity, PPO or HMO coverage – high, low, silver, gold, etc. These terms may still have relevance in the enumeration process to be developed by HHS.

Recommendations – HHS should:

- 2.1 initially enumerate all health plan legal entities as defined in the HIPAA legislation and further clarified in regulations at 45 CFR §160.103.
 - 2.2 determine at what level, including product (benefit package) level or other categorization, a health plan should also be enumerated, using input from stakeholders, and identify these in regulation.
3. **Observations for format and content of HPID:** The NCVHS heard testimony from a wide range of potential users of an HPID. The health plan community encouraged the concept of a simple number, citing that industry had learned from the NPI experience how there were other ways to acquire needed information about providers other than through an identifier with embedded intelligence. The provider community is primarily interested in getting information needed to appropriately direct transactions, communicate with applicable entities, match payments to fee schedules, verify an individual’s eligibility for health care services, and assist individuals in understanding their costs associated with the health care services to be received. While a few testifiers suggested some value of having embedded intelligence in the HPID, discussions during the hearings revealed that the desire

was for easy access to information – however that may occur. It was recognized that embedding intelligence in a HPID may add complexity and cost to the industry for maintenance of the number and ultimately limit its use for currently unanticipated purposes.

Recommendations – HHS should:

3.1 adopt an HPID that follows the ISO Standard 7812, with Luhn check-digit as the tenth digit.

3.2 adopt an HPID that contains no embedded intelligence.

- 4. Observations for the directory database to support the HPID enumeration system and process:** As any enumeration process will require collection of information associated with who or what has been identified, a directory database will be necessary to support information on entity demographics and other relevant identifying facts. The extent to which the database contains additional information useful in identifying entities associated with each plan, provider contract, etc. is subject to (1) what entity level is enumerated, (2) the extent of burden to maintain the database, and (3) the reliability of the data over time. At a minimum, there should be rules associated with the database concerning who or what may be enumerated, the minimum required data to be expected from entities, what additional, optional data is to be collected, who may access the database, what data may be available to be accessed, the required frequency of updates, and other functions if any.

Recommendations – HHS should:

- 4.1 establish an HPID enumeration system and process supported by a robust online directory database.
- 4.2 direct CMS to work with stakeholders including other federal agencies to identify the minimum necessary data elements for the directory database. Consideration should be given to including the Employer Identification Number (EIN), Taxpayer Identification Number (TIN), National Association of Insurance Commissioners (NAIC) identifier, Source of Payment Typology, and other identifiers that may assist in supporting the need to appropriately identify health plans in administrative transactions and in the updating, development and/or effective use of standards and operating rules. The database should be sufficiently flexible to enable additional information to be added initially at the discretion of the entity, and potentially in the future, as a requirement by HHS.
- 4.3 require the entity enumerated to maintain all information according to a published schedule of updates or more often as appropriate, to maintain accuracy. If there are no changes at the time of a scheduled update, the

date information was validated should signify that the entity has reviewed and is confirming the data as being current.

- 4.4 make available appropriate information from the HPID directory database to support the efficient and accurate exchange of information.
- 4.5 consider, for the future, requiring that the HPID system enable electronic transactions with the directory database for users or their systems to obtain information and route transactions more efficiently and effectively.

5. Observations specific to retail pharmacy implementation of HPID: NCVHS heard testimony that retail pharmacy transactions utilize the RxBIN/PCN identifier to facilitate their transaction processing and that changing to another identifier would significantly impact existing data flows in the retail pharmacy industry which are currently working very effectively. As such, the pharmacy industry requested an exemption from the requirement to only use HPID in retail pharmacy transaction because of the current success with the RxBIN/PCN identifiers for routing purposes.

Recommendations – HHS should:

- 5.1 not require the HPID to be used in place of the existing RxBIN/PCN identifier in retail pharmacy business and transactions.
- 5.2 require the use of HPID on the HIPAA-named standard transactions for retail pharmacy, where appropriately defined by industry through the ASC X12 and NCPDP processes.

6. Observations for implementation and timing: Smooth transitioning to the HPID was raised during the hearings as critical to be addressed. This was identified as especially acute for Medicaid programs currently using the NAIC identifier and the need for a separate identifier for Medicaid subrogation purpose. NCVHS also heard testimony concerning interest in grandfathering some existing ISO identifiers, but determined that the confusion in the industry that might ensue could be worse than the level of effort to make the change.

Timing associated with industry compliance of the ASC X12 v5010 and NCPDP D.0 financial and administrative transactions was also identified as troublesome. Along with modifications to accommodate v5010 and D.0 of the HIPAA standards, adoption of the HPID will have an impact on systems. Plan and provider information systems will require updating including expansion of data fields to accommodate the HPID, and crosswalks between existing proprietary identifiers and the HPID. Clearinghouses and vendors will need to update their systems and create crosswalk identifiers. Health plans will need to retool their systems to accommodate the new HPID, determine entities to be enumerated, communicate their HPIDs to trading partners, and accept the new HPIDs as valid on the transactions they receive. The HPID will also impact information systems that involve HL7 standard protocols.

Testimony from HL7 observed that it is likely that a new HPID may require changes to existing scheduling, registration, pre-admission, admission, and other information systems and their screens, work flow, and data elements collected, stored, displayed, and processed by those applications. Potentially tens of thousands of existing interfaces could be impacted by this change.

Recommendations – HHS should:

6.1 consider that the effective date of October 1, 2012 be interpreted as the date to begin registering for an HPID. As such, subsequent phases should include time for enumeration and testing before a final implementation date when the HPID must be used in compliant transactions. This will ensure sufficient time for publication of the regulation and development of the enumeration system and process. Phases should include:

- October 1, 2012 – March 31, 2013: Enumeration
- April 1, 2013 – September 30, 2013: Testing
- October 1, 2013: Implementation

6.2 describe in regulation the potential purposes and uses of the HPID, including its uses in standard transactions, potential uses for health information exchange, and others. While purposes should not be restricted, the initial focus should be on enumerating entities for use in the financial and administrative transactions required under HIPAA.

6.3 accommodate bulk enumeration of HPID as applicable.

7. Observations for testing: Experience with the enumeration and adoption of the NPI has demonstrated that sufficient time must be allowed for testing, including the ability to conduct dual processing with both existing proprietary identifiers and the HPID.

Recommendations – HHS should

7.1 provide sufficient time and guidance for testing the HPID in transactions prior to use.

7.2 allow for a period during which dual use of legacy health plan identifiers and the new HPID is permitted in the transactions as appropriate.

8. Observations for use of the HPID on a health plan identification card: NCVHS acknowledges that there is significant usage of health plan identification cards in the industry today. There is an implementation guide for identification cards available from NCPDP (for pharmacy cards) and a recommended implementation guide for medical cards created by WEDI. Additionally, there is strong support for using the HPID in these health plan identification cards.

Recommendations – HHS should

8.1 encourage the use of the HPID in health plan identification cards.

- 9. Observations relating to improving the use of standards and operating rules in support of HPID purposes:** Some testifiers indicated that much can be accomplished by increasing use of the financial and administrative transaction standards today, implementing appropriate operating rules, and ultimately incorporating what is needed in the standards. Each field in which an identifier is required by a health plan's companion guide should be identified and mapped to the level of entity required to be identified in the standard transactions. Enumerating each applicable entity and including applicable information in the HPID directory database should enable many provider and individual questions that arise in the course of processing transactions to be addressed. For example, when an 835 transaction is received by a provider, the provider should be able to identify the entity with which it has a contract and through use of the directory database may be able to reference the appropriate identifiers to then reference its applicable fee schedule to match the payment to the schedule. With the adoption of the HPID there needs to be clear instructions through operating rules and plan guidance documents for how to use the HPID in each field in each of the HIPAA transactions.

Recommendations – HHS should

9.1 strongly encourage the industry to collaborate to enhance operating rules for the financial and administrative transactions to support the use of the HPID.

NCVHS believes there is an opportunity created by the Affordable Care Act to increase adoption of health information technology tools to improve the effectiveness of the health care system. The industry has awaited a national health plan identifier for some time. As such NCVHS recommends that HHS implement these recommendations. NCVHS continues to stand ready to provide additional guidance or assistance to the Secretary on development of regulations for the HPID.

Sincerely,

/s/

Chairperson, National Committee
on Vital and Health Statistics

Enclosures:

Appendix A: Environmental Scan

Appendix B: List of Testifiers and Submitters of Written Testimony

Cc: HHS Data Council Co-Chairs



NCVHS

National Committee on Vital and Health Statistics

May 15, 2014

Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Findings from the February 2014 NCVHS Hearing on Prior Authorization for the Pharmacy Benefit; Health Plan Identifier (HPID); Electronic Fund Transfer (EFT)/Electronic Remittance Advice (ERA); and, Remaining Operating Rules

Dear Madam Secretary,

The National Committee on Vital and Health statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (DHHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS advises the Secretary on the adoption of standards and code sets for the HIPAA transactions. The Patient Protection and Affordable Care Act (ACA) {Sec. 1104 (b) enacted on March 23, 2010, calls for NCVHS to assist in the achievement of administrative simplification to “reduce the clerical burden on patients, health care providers, and health plans.”

Each year, NCVHS holds industry hearings to evaluate and review the standards, code sets, identifiers and operating rules adopted under the HIPAA and the ACA, and determine whether there is a need for updating and improving any of these standards and operating rules. NCVHS is pleased to present in this letter, findings from our February 2014 hearing. This letter summarizes common themes across various topics covered during the hearing, followed by findings, observations and recommendations on specific topics.

As we had indicated in our September 20, 2013 letter to you, significant changes continue to take place in terms of number, scale, pace and timing specifically with regard to implementation of the first set of standards and operating rules on electronic fund transfer (EFT) and electronic remittance advice (ERA); prior authorization; and, health plan identifier (HPID).

The following observations are drawn from the testimonies at the February 19, 2014 Subcommittee on Standards hearing.

Prescriber Prior Authorization for the Pharmacy Benefit

In 2004, the National Council for Prescription Drug Programs (NCPDP) organized a multi-industry, multi-Standards Development Organization task group to evaluate a prior authorization (PA) standard, particularly the medication prior authorization, that would support the needs for e-prescribing transactions and to develop a solution. Investigators found that the HIPAA-named PA standard (the X12N 278 v4010 or v5010), was not adequate to support medication PA because it was designed for procedures/services or durable medical equipment (DME) prior authorization and did not accommodate the information necessary to facilitate prior authorization. It also did not have a mechanism for providers to provide relevant information for e-prescribing. Consequently, the NCPDP developed and through its vetting process, received industry approval for e-Prescribing Prior Authorization transactions (included in the NCPDP SCRIPT Standard), which enables the healthcare industry to exchange prescriber-initiated prior-authorization requests for prescribed medications as part of the provider-patient encounter. The SCRIPT Standard was named in the Medicare Modernization Act (MMA) and is a requirement of Meaningful Use (MU) for e-prescribing transactions.

NCVHS had received a letter from the Designated Standards Maintenance Organization (DSMO) recommending the adoption of new electronic prior authorization transactions for use in electronic prescribing. Specifically the DSMO recommended naming the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions, for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit. The NCPDP and testifiers at the NCVHS hearing stated it is confusing to the industry to separate the SCRIPT Standard transactions into HIPAA transactions but it was unclear under which regulation prior authorizations would fall. Entities affected by the prior authorization processes include pharmacies, prescribers who use electronic prescribing, the Medicare Part D Program, and the Medicare Improvements for Patients and Providers Act (MIPPA) e-prescribing (eRx) incentive program, and the HITECH Electronic Health Record (EHR) Incentive Program.

While some testifiers indicated that the use of the SCRIPT Standard Version 2013101 Prior Authorization transactions would require completion of additional workflow processes at the prescriber level, there was overall consensus among the testifiers regarding the need for real time prior authorization at the provider level for electronic prescribing. Specifically, the prescriber needs to have at the point of service, access to the pharmacy benefit information to determine if the individual is covered under the pharmacy

benefit and what medications are available under the pharmacy formulary. This improves patient access to required medications.

Testifiers, including vendors, were in agreement that paper and telephonic prior-authorization is time consuming for prescribers and adds overhead costs. One testifier provided estimates obtained from journal articles that indicated that, prior-authorization accounts for a cost of \$2,161 to \$3,430 annually for each full-time equivalent physician.

Subsequent to the February 2014 hearing, NCVHS received supporting testimony from the America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA) in favor of adoption of the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions.

Recommendation 1: HHS should name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions as the adopted standard for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

Recommendation 2: HHS should adopt Recommendation 1 under the most appropriate regulatory sections and processes that would enable prompt industry implementation and at the earliest possible implementation time.

Health Plan Identifier (HPID)

Testifiers indicated that there is confusion on how the HPID/Other Entity Identifier (OEID) should be used. Many health plans face challenges with respect to the definitions of controlling health plan (CHP) and subhealth plan (SHP); the use of HPID for group health plans that do not conduct HIPAA standard transactions; and the cost to health plans, clearinghouses and providers if software has to be modified to account for the HPID. Testifiers questioned the impact on health plans, third-party payers (TPAs) and Administrative Services Only (ASO) self-insured groups and the degree of granularity required to enumerate. Others expressed concerns that the HPID database would not be accessible and without public access to the HPID database the identifier is of no value to trading partners; validation could not be performed; a crosswalk would not be possible among Medicaid proprietary plans; and the data collection does not include reference to the Bank Identification Number/Processor Control Number (BIN/PCN) used in pharmacy claims processing. Concern was also expressed that self-insured health plans are not aware of the requirements that apply to them.

NCVHS heard the challenges expressed by testifiers at the hearing relating to the value of the HPID and its relationship to the payer ID and whether the HPID is intended to replace any existing identifiers. Because of the questions raised, NCVHS plans to probe the HPID issues further at its Standards Subcommittee hearing in June 2014.

Recommendation 3: To mitigate the confusion about the HPID among the health care industry, HHS should:

- **provide more guidance on the HPID /OEID specifically, clarifying when an HPID should be requested;**
- **clarify the definition of health plan, CHP and SHP;**
- **define how health plans determine whether they have CHPs or SHPs;**
- **identify whether HPID, which is not intended to replace the payer ID, should be used for payer identification;**
- **explain the applicability of HPID to self-insured and fully-insured group health plans, specifically the extent to which all self-insured plans are required to obtain a HPID, where the HPID is to be used in the transaction and when a third party administrator is the entity processing the transaction on behalf of the self-insured plan;**
- **define the purpose of the OEID;**
- **provide clarification with respect to public access to HPID/OEID data bases;**
- **provide educational outreach to explain the use and requirements of the HPID/OEID; and**
- **provide guidance on benefits and value of the HPID for health plans and providers and administrative simplification requirements;**

Electronic Fund Transfer (EFT)/Electronic Remittance Advice (ERA)

Adoption of the EFT and ERA operating rules started January 1, 2014. Testifiers reported that most HIPAA covered entities have implemented the EFT and ERA operating rules and the EFT standard and, it appears implementation has been reasonably smooth. A testifier reported that some EFTs received from CMS are not formatted according to the EFT standard or the NACHA Operating Rules. The rate of adoption and the effect of adopting EFT and ERA operating rules will be evaluated by the health care industry this year.

The volume of EFTs has grown each year and it is expected that this trend will continue through 2014. Enrollment is seen as a factor in the success of the

EFT and reducing inconsistency across the payers should facilitate further adoption and reduce costs. Testifiers were in agreement that the use of EFTs and ERAs has resulted in savings of \$.50 to \$1.25 per payment with the capability of saving approximately \$3.00 for each electronically settled claim.

Concerns were expressed by many testifiers with a new emerging issue, the use of virtual cards and credit cards by health plans to pay and transfer funds to providers for health services rendered.

Virtual cards are generally 16-digit credit card numbers (without the plastic card) sent by a payer to a provider to pay for services. Providers then enter the virtual card number in their regular payment system to authorize the payment, and subsequently receive the payment via the Automated Clearing House (ACH) in their merchant bank account.

Issues raised by testifiers included the additional fees charged for each virtual card authorization transaction (as much as 5% of the payment); transaction fees that are not always transparent; staff time required to manually key in credit card information; additional time required to resolve for entry errors; standard electronic remittance advice not being equipped to carry credit card information; multiple claims being represented on one virtual credit card complicating reconciliation; providers not being afforded the opportunity to choose using a virtual credit card; and, questions if using virtual cards are in compliance with HIPAA standards. Other testifiers described situations where virtual credit cards with a fee was the only payment option offered to providers; applying a fee if providers used the standard; incentives such as providing faster payment, if the virtual credit card is used; disincentives such as slower payments and application of a fee, if providers wished to use the standard; and excessive fees to conduct standard transactions. However, some testifiers described advantages to using the virtual credit card indicating that large numbers of providers currently accept credit cards, as well as ACH; provider enrollment is not necessary; it results in reduction in payer print/mail costs; and, there are near zero payer bank fees, as the provider carries all the costs. Use of the trace number (TRN), that is, re-association of payment and the remittance advice, is seen as the key to improving efficiency for providers with the healthcare EFT standard. The TRN cannot be used with the virtual card, as a HIPAA compliant X12 835 version 5010 ERA cannot be created to support a credit card payment.

Recommendation 4: To address the concerns raised by the health care industry regarding the use of credit cards, including virtual cards, for electronic fund transfer transactions, HHS should:

- **explore the use of virtual credit card payments to determine if its use is compliant with the EFT standard and if providers are afforded**

the opportunity to use the HIPAA EFT standard rather than the virtual credit card;

- **work with the health care industry to be aware of the practices that exist to encourage the use of the standard for the EFT, instead of the virtual card; and**
- **work with the health care industry to ensure greater transparency.**

Recommendation 5: HHS should assure that all HIPAA covered entities comply with the adopted EFT standard. Specifically, entities should:

- **correctly format the TRN Segment in the Addenda portion of the CCD+ to assure that providers are able to match an EFT to its associated ERA;**
- **use the standard description required by the NACHA rules so that the health care EFT is easily recognizable by someone reading an account statement; and**
- **use the X12 835 version 5010 TR3 Report in place of the version 4010 for the TRN Reassociation Trace Number .**

Operating Rules for Remaining Transactions

Progress has been made and continues to be made in developing the remaining operating rules, which are expected to be drafted by the end of 2014. The remaining operating rules include health claims or equivalent encounter information; enrollment/disenrollment in a health plan; health plan premium payments; referral certification and authorization; and, health claims attachments. Many challenges exist for developing the operating rules for the health claim attachments particularly relating to ensuring privacy, transport and enveloping attachments, security and authentication, message interaction, response times and determining return on investment. Standards have been adopted for health claims or equivalent encounter information; enrollment/disenrollment in a health plan; health plan premium payments; and, referral certification and authorization. A standard has not been developed for the health claim attachments.

Section 1173(a)(2)(B) of the HIPAA, identified a health claim attachment as one of the transactions for which electronic standards were to be adopted. The NCVHS Subcommittee on Standards held a hearing on health care claim attachments on November 17, 2011 and a second review at the February 27, 2013 hearing. In the June 21, 2013 letter, we explained that a final rule had not be developed subsequent to the publication of a proposed rule in 2005, due in part to questions about the maturity of the standards that had been

recommended for adoption and the ability for users to implement them. We provided many recommendations for the development of a rule to adopt standards for electronic attachments.

Health care clinical attachments continued to be addressed at the February 2014 hearing with regard to the development of the remaining operating rules. Testifiers opined that operating rule development be aligned with meaningful use and the health insurance marketplace/exchanges. Future operating rules should be evaluated based on return on investment (ROI), industry readiness, and industry constraints. Additional hearings on these issues will be planned in the future.

NCVHS does not have any recommendations regarding this topic at this time. Rather, we will continue to work with the operating rule authoring entity to monitor the development of operating rules for the remaining transactions and receive the recommended operating rules later this year. NCVHS anticipates that recommendations will be provided to the Secretary after the operating rules have been developed and submitted to NCVHS for evaluation.

Closing Comments

NCVHS recognizes the challenges that the health care industry faces today and will continue to experience over the coming years as they adjust to these transformative changes. NCVHS will continue to support your efforts to increase the adoption of standards and operating rules that help move the industry forward with technology to achieve greater efficiency.

Sincerely,

/s/

Larry A. Green, M.D. Chairperson,
National Committee on Vital and Health Statistics

Cc: HHS Data Council Co-Chairs

September 23, 2014

The Honorable Sylvia M. Burwell
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Findings from the June 2014 NCVHS Hearing on Coordination of Benefits, Health Plan Identifier (HPID), and ICD-10 Delay

Dear Madam Secretary,

The National Committee on Vital and Health Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (DHHS). Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NCVHS advises the Secretary on the adoption of standards and code sets for the HIPAA transactions. The Patient Protection and Affordable Care Act (ACA) {Sec. 1104 (b) enacted on March 23, 2010, calls for NCVHS to assist in the achievement of administrative simplification to “reduce the clerical burden on patients, health care providers, and health plans.”

Each year, NCVHS holds industry hearings on standards, code sets, identifiers and operating rules adopted under the HIPAA and the ACA to evaluate the need for updates and improvements to any of these standards and operating rules. NCVHS is pleased to present in this letter, findings from our June 2014 hearing. This letter summarizes common themes across various topics covered during the hearing, followed by findings, observations and recommendations on specific topics.

Coordination of Benefits

Coordination of benefits is the process of coordinating payments made on behalf of an individual who has more than one health plan payer. Testifiers were in agreement that it is the lack of common and consistent practices in business operations and standardization of operating rules, rather than the adopted standard (837 COB) itself, that gives rise to current coordination of benefits (COB) issues. These issues include:

- Lack of consistency in the rules for initiating benefit and payment coordination between payers and providers.

- Inconsistent exchange of information between payers to fulfill benefit and payment coordination.
- The need to improve access to and communication of information from payers to providers that identify coordination of benefit needs in the front-end, early in the eligibility process rather than in the back-end when claims are being filed.

It is NCVHS' understanding that Operating Rules are under development to address these issues, and should be completed by early 2015. At the current time, NCVHS does not have any recommendations. However, NCVHS will hold additional hearings once Operating Rules are developed and submitted to NCVHS for consideration.

Health Plan Identifier (HPID)

Health Plan Identifier (HPID) was discussed at the February 27, 2014 hearing. Findings from this hearing were summarized in our May 15, 2014 letter to the Secretary. At the June 10, 2014 hearing, HPID was again discussed. Some of the issues described in the May 2014 letter were highlighted and emphasized again by testifiers. These included

- 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.

A consistent message heard strongly across the industry at the June, 2014 hearing was the lack of benefit and value in the use and reporting of HPIDs in health care transactions. Testifiers were in consensus that HPID should not be required to be used in administrative transactions and it should not replace the payer ID currently used by the health care industry.

NCVHS understands that the original intent back in the mid-1990s of the use of HPIDs and OEIDs was to identify health plans and clearinghouses *to facilitate routing of transactions to appropriate payer recipients*. However, the industry has moved to the implementation of a standardized national payer identifier based on the National Association of Insurance Commissioners (NAIC)

identifier. This identifier is now widely used and integrated into all provider, payer and clearinghouse systems. This payer ID is currently the basis for routing day-to-day administrative transactions from a provider to the appropriate payer, and modifying it would create a significant disruption in the routing and processing of all administrative transactions.

NCVHS also understands that the HPID has been given other purposes, including use in other CMS programs such as insurance exchanges/ marketplaces and with health plan compliance certification under the Affordable Care Act.

In consideration to this testimony, NCVHS recommends the following:

Recommendation 1: HHS should rectify in rulemaking that all covered entities (current and future health plans, providers and clearinghouses, and their business associates) will not use HPID in administrative transaction, and that the current payer ID will not be replaced with HPID.

Recommendation 2: HHS should further clarify in the Certification of Compliance final rule, when and how the HPID would be used in health plan compliance certification and if there will be a connection with the Federally-facilitated Marketplace.

ICD-10 Delay

Testifiers were consistent in their message that another delay in implementing ICD-10 would add to the already substantial costs of delays arising from stopping and re-starting processes and re-education and training of staff. Testifiers expressed (1) concern that the deadlines will continue to be shifted, (2) the need to continue efforts to ensure that organizations not ready to implement ICD-10 will have a pathway for readiness, (3) the need for organizations to use the delay to achieve end-to-end testing, and (4) the need to inform the Congress regarding ICD-10 readiness.

Recommendation 3: HHS and industry leaders should proactively emphasize to Congress the merits of ICD-10, progress made by the health care industry in its readiness to implement ICD-10, and, costs to the health care industry associated with any further delay.

Closing Comments

NCVHS recognizes the challenges that the health care industry faces today and will continue to experience over the coming years as they adjust to these transformative changes. NCVHS will continue to support your efforts to increase the adoption of standards and operating rules that help move the industry forward with technology to achieve greater efficiency.

Sincerely,

/s/

Larry A. Green, M.D. Chairperson,
National Committee on Vital and Health Statistics

Cc: HHS Data Council Co-Chairs