AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

May 17, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier (HPID); Addition to the National Provider Identifier Requirements; CMS-0040-P; RIN 0938-AQ13

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to submit the following comments in response to the proposed rule on a standard for a HPID. The adoption of a HPID provides an invaluable opportunity to eliminate the ambiguity that makes health care transactions so costly today. This ambiguity stems from the fact that the term "health plan" can mean a host of different things, ranging from the specific health insurance product an individual buys to the national company that sells that product, and including each of the intermediaries involved in the multitude of transactions which occur during the administration of our third-party payment system. The adoption of a robust HPID has the potential to eliminate all this ambiguity, thus reducing costs dramatically for all the trading partners. **While we support the proposed rule for an HPID, we believe that refinements to the proposal, which are specified in greater detail below, are necessary to bring about substantial cost savings and meaningful administrative simplification reforms.**

Entities receiving identifiers

The AMA supports the Department of Health and Human Services' (HHS) goal of uniform identifiers for all entities that perform health plan roles as a foundational step toward administrative simplification. We commend HHS for acknowledging the need for third-party administrators, provider networks, repricers, and other payers to obtain an ID and be identified in the standard transactions. The AMA also appreciates HHS' consideration of

allowing the property and casualty payers and their business associates to have the option to request an entity identifier (HPID or other entity identifier (OEID)), as appropriate, as workers' compensation payers specifically and the property and casualty industry generally begins to move away from paper bills and attachments and increases its use of Health Insurance Portability and Accountability Act (HIPAA) standard electronic health care transactions. We encourage all of these entities to obtain an identifier and strongly encourage all HIPAA covered entities to require their partners to obtain an identifier and require the use of the entity identifiers in the standard transactions.

Enrollment and registry

As indicated above, the AMA strongly supports the discrete identification of each entity involved on behalf of the payer community in each of the electronic health care transactions, whether the entity is involved as the fiduciary with legal responsibility for paying claims, or as the administrator responsible for administering any aspect of the benefits, or as the holder of the participation contract with the physician or other health care provider, or as the place where the transaction should be routed. For this reason, we are concerned about the aspect of the proposed rule which would allow a "controlling health plan" to substitute its HPID for that of the more specific entity actually handling the transaction. We are also concerned that the definition of "controlling health plan" may not be sufficiently broad enough to encompass the various legal structures currently utilized by the various national third party payers. **We urge HHS to broaden the definition of "controlling health plan" to encompass any and all potential legal relationships between holding companies and their subsidiaries that hold health insurance licenses.** We also urge HHS to require that the "controlling health plan" as thus redefined be required to obtain an HPID for each of its subsidiaries involved in the health care delivery system, regardless of which of the four roles listed above that entity plays, as this would greatly assist in reducing confusion and operationalizing the use of the assigned identifiers. The AMA recommends that this "controlling health plan" be able to apply for an entity identifier and update the registry for all its subplans. The AMA also encourages HHS to provide the ability for bulk entity identifier submission and update of the registry by a designated HPID administrator or other entity, such as a third-party administrator (TPA) or administrative service organization (ASO) to simplify the process.

The composition of the registry will be a significant contributing factor in the ease of implementation of the entity identifiers. Please review Attachment 1 that was previously submitted to the National Committee on Vital Health Statistics (NCVHS) on our recommendations for the HPID registry data points.

Routing entity versus transaction destination

The AMA is concerned that the proposed rule seems to conflate need for an identifier in the transactions for the different entities that perform the various health plan roles, with the need to resolve the assignment of electronic data interchange (EDI) addresses for clearinghouses

and other entities that route claims between destinations. These EDI addresses are placed on the outside transaction envelope in order to route the contents of a standard transaction to its destination. We see these as separate and distinct issues that need to be resolved through different types of identifiers as, for among other reasons, EDI addresses are needed for all types of covered entities, not just health plans.

We see the primary purpose of the HPID as eliminating the ambiguity that currently permeates the standard electronic health care transactions because of the numerous different ways in which health plan functions are performed by numerous different entities and the numerous ways the term "health plan" is interpreted. This ambiguity undermines the value of the electronic transactions by requiring repeated manual interventions.

HHS, through this proposal, could clarify both the identification of entities performing health plan roles and the identification of EDI addresses on the transaction envelopes by revisiting the definition of a health plan in the HIPAA regulations. The relevant HIPAA regulation, 45 CFR § 160.103, defines the term "health plan" to cover virtually every entity that provides or funds health plan benefits. However, in common usage, the term "health plan" can mean a host of different things: it can range from the specific health insurance product an individual buys to the national company that sells that product, and can include each of the intermediaries involved in the multitude of transactions that occur in administering our third-party payment system.

We recommend that all entities that serve in health plan roles, such as health plans, provider networks, third-party payers, repricers and others, be required to receive an HPID and those entities that only route transactions between specified destinations, such as clearinghouses, have the option to voluntarily receive an OEID, which would serve as the EDI routing address on the transaction envelope. We believe the Patient Protection and Affordable Care Act (ACA) and the HIPAA rule support this concept, as the relevant portions of both the ACA and the HIPAA regulations indicate that the HPID should provide a meaningful identification system for health plans, as their identities are relevant to the HIPAA standard transactions. While the routing of transactions is certainly a necessary aspect of the standard electronic health care transactions, that routing involves all covered entities, not just health plans. Moreover, an HPID system that merely routes transactions is not sufficient to accomplish the goal of automating health care transactions as the address for a transaction has no necessary relationship to the entity that has responsibility for the transaction. Therefore, allowing those trading partners that need them to obtain OEIDs for EDI routing purposes would further the use of electronic health care transactions, while still ensuring that the HPID serves its principal purpose of identifying the entities engaged in health plan roles.

Section 1104 of the ACA refers to existing law on unique health plan identifiers (42 U.S.C. 1320d–2(b)), which states in part that in adopting an HPID, the Secretary "shall take into account multiple uses for identifiers…." Moreover, the HIPAA regulation,

45 CFR § 160.103, does not refer to routing numbers. Rather, it defines the term "health plan" to cover every party that funds health plan benefits. Furthermore, the Centers for Medicare and Medicaid Services (CMS) has consistently pursued specificity in its adoption of other identifiers. For example, CMS refused to allow a large employer made up of separate corporations with its own employer identification numbers (EINs) to apply the parent's EIN to transactions involving its subsidiary corporations. Rather, CMS insisted that the EIN on the individual's W-2 form, which identified the direct employer, had to be reported in the enrollment transaction. Similarly, the National Provider Identifier (NPI) is very specific, requiring an NPI for a hospital system and also for each constituent separate entity, such as an affiliated surgery center. The same drill-down method applies to medical practices that have their own NPIs at the entity level (NPI Entity Type 2) and then a separate NPI for each constituent physician or other health care professional (NPI Professional Type 1). Thus, the enumeration of every entity that acts on behalf of any health plan listed in the regulation in connection with any of the HIPAA Transactions and Code Sets (TCS)—and of each separate benefit plan offered by each of those health plans—is, if anything, more consistent with the intent of the ACA than a system that merely establishes routing numbers.

As drafted, the proposed rule would take only the first step toward creating complete transparency for patients and physicians by creating an identifier that could be used by the entities that serve in health plan roles. As will be discussed in more detail below, **we believe it to be critical to achieving the automation efficiencies necessary for significant cost savings that HHS take the next step and mandate that each entity that plays a health plan role obtain an HPID.** Because of the critical importance of the HPID to the automation of the health care delivery system and cost of health care, we also respectfully request that HHS reconsider the need for the patient-specific benefit plan ID and the standard format for a contracted fee schedule identifier detailed in Attachment 2 as previously recommended by the AMA. We acknowledge the challenge which the health insurance industry may face in transitioning to an identification scheme which both brings transparency to the health insurance products each of these companies sells, and does so in a fashion which is consistent across the entire health insurance industry. However, if we are to enable consumers to truly shop for health insurance like they do for other major purchases, and eliminate the extraordinarily high administrative overhead physicians, hospitals, and other health care providers incur today in grappling with the multitude of different systems the various health insurers have established, **the focus of the HPID must be shifted from the payer-centric system of today to a system which provides patients and their health care providers with the information they need to know to navigate each encounter.**

<u>The need for clear enumeration of each entity that plays a health plan role within the standard transactions</u>

We strongly encourage HHS to mandate that each entity that performs a health plan role obtain an HPID, rather than simply authorize these entities that are not otherwise acting as health plan fiduciaries to obtain an OEID. We commend HHS' requirement to require all covered entities to use an HPID whenever a covered entity identifies a health plan in a

covered transaction. We appreciate HHS' consideration of rephrasing this requirement for all covered entities to use an HPID whenever a "covered entity or other entity is serving in a health plan role" in a covered transaction. **We also encourage HHS to define "health plan role" to include each of the following functions: 1) health plan fiduciary with the financial responsibility for paying claims; 2) health plan administrator with the responsibility for administering some or all of the health plan's activities; and 3) health plan provider contracting agent, with the responsibility for administering participation contracts with health care providers pursuant to which the health plan obtains discounted rates for services provided to health plan beneficiaries.**

It is rare that all this information is included in the electronic transactions today. Indeed, there is no way that the current "payer ID" can communicate all this information. The current lack of clear identification of each of these attributes adds enormous cost to the health care system, as all parties are forced to resolve these ambiguities with manual processes, including telephone calls, faxes, letters, e-mails, and appeals. There are billions of dollars of cost savings associated with a robust health plan identifier system that does more than just identify the "controlling health plan" as defined in the proposed rule.

The need for a patient-specific benefit plan ID

With respect to our proposal for a benefit plan specific ID, we understand that today many health insurers enumerate at the purchaser level (group number), rather than at the patient level. However, from the perspective of patients, physicians, and other health care providers who are engaged in the receipt and provision of medical care, only the patient-specific benefit plan information is relevant, and that information is routinely necessary ***prior*** to the patient encounter. Assuming increasing numbers of people purchase coverage directly from Exchanges as envisioned by the ACA, the need for a patient-specific benefit plan identifier will only grow. This information is needed at the point of service, and therefore is needed on the eligibility response as well as the electronic remittance advice (ERA). Currently, payers are required to provide this information on the electronic remittance advice in text, which is a suboptimal solution as the different formats make automation difficult if not impossible.

The need for a national standard fee schedule identifier format

While there does not need to be an HPID assigned to each separate fee schedule between each health insurer (or its contracting agent) and each physician or other health care provider, if we are to eliminate the unsustainably high administrative overhead of the current system, **there should be an industry standard format for a payer-assigned fee schedule identifier, and a mandate that each entity which serves as a contracting agent issue a unique fee schedule identifier in conformance with that standard for each separate fee schedule.** Only with an unambiguous fee schedule identifier will physicians and other health

care providers be able to automatically post and reconcile claims payments from multiple payers for multiple products.[1]

Again, we do not intend to minimize the challenge the health insurance industry may face in moving to a transparent, industry standard identification scheme which meets the needs of the patient, physician, and other health care provider communities. Nor do we question the importance of robust operating rules to accompany the HPID enumeration scheme to ensure the HPID enumerators are indeed issued and applied consistently and effectively throughout the health care delivery system. **If the complete HPID system does not establish a unique identifier for each element of the system, which must be identified to meet the information needs of patients, physicians, and other health care providers, as well as those of health insurers, there is simply no way operating rules alone will be able to eliminate the ambiguity which plagues the current system.** And, so long as the system is rife with ambiguity, there is no way to automate the multitude of transactions which now require manual intervention. We strongly support a multi-payer system, but there must be increased standardization and transparency to permit consumers to better compare health insurance offerings and to help all parties eliminate the administrative waste that plagues the current system. In that light, the AMA has been collaborating with payers and vendors in the effort to develop a downloadable fee schedule for health care that has become a recognized Accredited Standards Committee (ASC) X12N standard transaction. We look forward to joining interested stakeholders in piloting this concept this year. Access to the ASC X12N 832 health care fee schedule standard transaction implementation guide is available at: www.wpc-edi.com.

Operationalizing the HPID by clear reporting instruction for the ASC X12N 005010 Version of the HIPAA standard transactions

We commend HHS' commitment to increase the standardization of the reporting of entities within the HIPAA standard transactions, as well as the laudable goal to increase the levels of automation in physician practices. While we appreciate the effort to create a robust HPID and the suggestion in the proposed rule that the ASC X12N 005010 version of the HIPAA standards and existing operating rules provides the mechanism to do so, we must respectively disagree. The AMA does appreciate the dedication and innovation of the X12N leaders, co-chairs and workgroup members who are committed to reducing manual workflow through automation. The AMA and many others have been diligently working with X12N to ensure the next version of the standard transactions have the fields and instructions to ensure the appropriate placement of health plan and other identifiers to provide the transparency and cost savings associated with the use of these identifiers. This includes placement of a payer's physician-specific fee schedule identifier.

[1] We are not proposing that the fee schedules themselves be made public. The purpose of the fee schedule identifier is simply to ensure clear, automated communication between payers and providers as to which of the often several different fee schedules should be applied to each claim.

We encourage HHS and the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) to reach out to ASC X12N to identify the enhancements made in the ASC X12 006020 version of the HIPAA standard electronic health care transactions, both to maximize the potential that operating rules enhance the functionality of the ASC X12N 005010 version to the extent feasible, and to create an appropriate bridge strategy for transition by the health care industry to the enhancements contained in the ASC X12 006020 version. A clear understanding of the future functionality of the X12N standard transactions will guide HHS in its determination to reach out to ASC X12N to potentially develop a 005010 addendum, and will guide CAQH CORE to develop the operating rules that will provide clear instruction where these entity identifiers should be placed in the standard transactions. The success of either bridge strategy, a ASC X12N 005010 addendum or operating rules, should be measured based on its ability to create a viable work-around of the limitations in the current ASCX12N 005010 version of the standard transactions to maximize the automation value of the new HPID and OEID identifiers, while also creating a workable bridge toward the ASC X12N 006020 and future versions of the transactions. **The health care industry must ensure the communication rails created through the ASC X12N 004010 and ASC X12N 005010 version of the HIPAA transaction and code sets are solidified, and that the HIPAA addendum or CAQH CORE operating rules used to implement the HPID and OEID identifiers now will streamline the transition to the enhanced functionality that is included in the ASC X12N 006020 and future version of these standards.**

The proposed rule indicates the current CAQH CORE operating rules for eligibility would allow for the transparency the AMA is requesting. **While we support the CAQH CORE operating rules, unfortunately, the current eligibility operating rules do not provide the identity of the entity that holds the contract with the physician. This is a crucial piece of information, particularly because the HPID proposed rule does not address the identification of the patient-specific benefit plan nor a standard format for the specific-fee schedule applicable to the encounter.** In the absence of this critical information, the cost savings that could have been realized with the autoposting of payments and reduced calls associated with disputes over the applicability of a discount to a particular patient encounter will not be achieved. For the reasons stated previously, this information should be made available to the physician and practice staff at the point of service.

We envision a fully automated process for health care transactions. We contend that HPID can be used with other standard identifiers within the ASC X12N 005010 version of the health care standard transactions to facilitate automated transactions and claims adjudication processes. To illustrate the concept, we will use the ASC X12N 005010 270/271 eligibility request and response as an example. The following representative examples are intended to demonstrate possible solutions; the final requirements would need to be determined by and adopted by the appropriate standard setting and operating rules bodies.

HIPAA ASC X12 005010 271 eligibility response standard transaction
Receive on the X12 271 eligibility response standard transaction the HPID/OEID of entity responsible for receiving the claim, HPID of entity that serves as the claim administrator, HPID of the entity that holds the contract with the physician or other health care provider, the HPID of the entity responsible for funding the benefit, and the HPID of the patient's specific benefit plan. In addition, the contracting entity would provide the identifier necessary in a standard format to access the fee schedule applicable to the claim. **Possible locations on the 005010x279 271 for required information:** Claim Routing entity: Loop 2120C NM101 = PR, NM108 = XV (HPID/OEID) *(also can be found on Member ID card)* Claim Administrator: Loop 2120C NM101 = PR, NM108 = XV (HPID) Product/Plan: Loop 2110C EB05 = Plan name or product name (Currently Required) Contract Responsibility: Loop 2100C REF01 = CT, REF02 = HPID Key to Fee Schedule: Loop 2100C REF01=CT, REF02 =possibly require fee schedule number embedded in Contract Number (OPTIONAL) Funding Responsibility: Loop 2120C NM101=P5, NM108 = XV (HPID) **Note:** All usages of HPID/OEID should be supported by standard usage rules. Access the 6020 version of the ASC X12 standard transaction implementation guides at www.wpc-edi.com for specific fields, loops and identifiers specified to hold the entities that perform health plan roles as well as the fee schedule identification.

Cost savings

The cost savings contemplated by the proposed regulation can not be realized without the consistent reporting of all entities that perform health plan roles, including the identification in both the eligibility and ERA transactions of the entity that holds the participation contract with the physician, identification of the patient-specific benefit plan, and the claim specific fee schedule identifier. **The availability of this information will enable practice management system vendors to create the functionality to utilize this information in a user-friendly, integrated, and affordable solution.** We therefore, commend HHS for taking the first step as included in the proposed rule, and strongly encourage additional action as recommended in these comments.

Transition Phase—Learning from the past

It will be important to carefully consider how best to transition to the HPID/OEID as many of the trading partners currently use legacy numbers. Running dual identification numbers became quite cumbersome during the transition to the NPI despite the fact that it allowed for interim steps to implementation. **We strongly encourage HHS to work closely with all the key stakeholders to ensure feedback is sought at key junctures along the way to**

HPID/OEID implementation. Key stakeholders should also be encouraged to assist CMS with the critical outreach that will be required to ensure sufficient awareness that will lead to the successful implementation of HPIDs/OEIDs.

Infrastructure and required modifications

A number of lessons were learned during the NPI enumeration process that should be taken into consideration as plans for HPID implementation continue:

- Every effort must be made to ensure physician and other health care provider payment interruptions are averted. Among other things, clear and flexible guidance must be created and shared widely on opportunities to receive advance payments.

- Clear messaging from HHS and all its contractors is needed in order to ensure a smooth transition.

- HHS should work closely with all HIPAA-covered entities and the vendor community to ensure feedback is sought at key junctures of the implementation process and on critical outreach.

- Education on interim steps necessary to implementation will be helpful.

As noted above, running dual identification numbers, HPID and legacy numbers, could be cumbersome and inefficient for physicians and other health care providers, yet they may become necessary to facilitate a smooth transition.

Conclusion

Given the complexity of the third-party payment process, only robust health plan identification requirements can achieve the types of efficiencies and significant cost savings for the health care system that Congress intended to achieve when it mandated the promulgation of national identifiers and standard electronic health care transactions. Only when physicians and other health care providers receive complete, accurate, and transparent information concerning all relevant aspects of a health care transaction that is covered by a third party payer on a real-time or near real-time basis can these transactions be fully automated.

We believe that the adoption of a robust HPID standard for use within the ASC X12N 005010 version health care standard transactions will achieve this goal in the most expeditious manner. While the adoption of an HPID as we have proposed would not entirely eliminate manual processes, we believe it would eliminate the need for manual processes in 80–85 percent of the transactions in which they are currently required. Thus, the adoption of an HPID as we have proposed would dramatically increase the value of electronic transactions to the provider community and justify the investment necessary to take advantage of them. This increased automation would lead to significant savings across the

health care industry. Indeed, studies have indicated that as much as $210 billion could be saved through standardization and simplification of the health care billing, payment and claims reconciliation process.[2] **However, the achievement of savings of this magnitude requires refinement of the proposed rule to include all of the following:**

1) **Mandatory assignment of an HPID to each entity that serves in any of the three health plan roles including: 1) health plan fiduciary with financial responsibility for paying the claims; 2) health plan administrator responsible for administering some or all of the health plan's activities; and 3) health plan provider contracting agent, with the responsibility for administering participation contracts with health care providers pursuant to which the health plan obtains discounted rates for services provided to health plan beneficiaries;**
2) **Implementation of a standard identification process for the specific patient benefit plan;**
3) **Adoption of a national standard format for payers to utilize to provide health care providers the payer has identified as being "in-network" with the contracted fee schedule identifier identifying the specific fee-schedule applicable to services provided to each beneficiary;**
4) **Adoption of the OEID as an EDI routing address for those covered entities and other trading partners who need an ID for this purpose beyond the HPID or NPI; and**
5) **Authorization for workers compensation carriers and other property and casualty insurers to obtain HPIDs and OEIDs at their discretion.**

We appreciate your consideration of these comments, and continue to urge CMS to embrace the opportunity created by the ACA and adopt a complete, robust HPID enumeration system which addresses the information needs of the patient and provider communities. Should you have questions or require additional clarification about these comments, they may be directed to Mari Savickis, Assistant Director, Division of Federal Affairs, at 202-789-7414 or mari.savickis@ama-assn.org.

Sincerely,

James L. Madara, MD

Attachments

[2] PNC Bank (2007); Commonwealth Fund (2007); RAND Corporation (2005); PricewaterhouseCoopers (2008).

Attachment 1

Enclosed you will find our recommendation regarding the registry associated with the HPID.

Single Companion Guide. We strongly encourage the movement toward a single, binding "Companion Guide" for each HIPAA standard transaction that would consist of a complete set of requirements, processes, and operating rules necessary to electronically submit and receive each HIPAA standard transaction. Those elements that would remain from the over 1,200 companion guides that exist today, such as contact and routing information could be placed in the HPID registry. During the transition to a single standard companion guide for each of the standard transactions, if there were any ASC X12 005010 version or related fields in a standard transaction that still had unique situational variables than those contained in the uniform implementation guide, these could be listed with the health plan's information in the HPID registry.

Registry Contents. The HPID registry should include full demographic information related to that health plan and all information necessary to enroll with health plan to send and receive standard transactions as well as transmit standard transactions to the correct destination. In addition, the registry would include specific instructions explaining how questions could be directed to the health plan when necessary. Further, identifying the health plan type, the health plan's relationship with any other entity serving in a health plan role, and if the health plan utilizes a different network of physicians through a rental physician network identification of the physician network, by region, should also be included in the HPID registry.

Cross-Walk Legacy Identifiers. The registry should also include common identifiers to allow a search of the various entities performing health plan roles. These identifiers could include, the entity's tax identification number (TIN), National Association of Insurance Commission (NAIC) number or other commonly known number that would link all of the health plans' HPIDs together.

Access to the Registry. In addition to the content of the HPID registry, the functionality it provided to end users will also be critical to its utility. The database search option should provide options to access information from the registry. To achieve the goals of administrative simplification and to streamline standard transactions, we are requesting additional functional options such as: download capabilities; near real-time updates; and the ability to electronically ping databases from a practice management system or other provider administrative systems based on selected search criteria. This functionality would be extremely valuable to providers, billing services, clearinghouses, hospital systems, payers and others.

Usable Download Format. The format for downloads should utilize a common design structure that can be easily imported into databases or other tools for ease of use, such as a text delimited file.

Health Plan ID (HPID) Registry data points

- Date the record was last updated and by whom
- Status of HPID – active date, pending with activation date, termination date

Demographics

- Type/Category of entity being identified by this HPID
- Legal name and alternative names of the entity being identified by the HPID
- Identifier/s of the entity being identified by the HPID. This should include one or more of the following: the NAIC company code; Tax ID number; Pharmacy Bank Identification Number (RxBIN); Pharmacy Processor Control Number (RxPCN); or other common identifiers currently used by health plans.
- Postal address, phone, fax, email, web site and Internet portal address, if applicable
- Parent entity's HPID or subsidiaries' HPID clearly distinguished in the record.

Contact Information

- Enrollment Contact/Information for Standard Transactions
- Entity Contact Information for Inquiries
    - Name of person and/or position, address, phone, fax and email to be contacted with claim inquiries
    - Name of person and/or position, address, phone, fax and email to be contacted with eligibility inquiries (if different from above)
    - Name of person and/or position, address, phone, fax and email to be contacted with prior authorization requests (if different from above)

- Name of person and/or position, address, phone, fax and email to be contacted to enroll to receive electronic transactions (if different from above)

Routing Contact/Information for Standard Transactions

- Name of person and/or position, address, phone, fax and email to be contacted to enroll to receive electronic transactions (if different from above)
- Specific routing information for each standard transaction for each mode of transaction (i.e., nearly real-time batch) for at least the following standard transactions:
  - ASC X12 837 Claims
  - ASC X12 835 EOB/RA/EFT
  - ASC X12 276 Claim Status
  - ASC X12 277 Claim Status Response
  - ASC X12 270 Patient Eligibility Request
  - ASC X12 271 Patient Eligibility Response
  - ASC X12 278 Referrals
  - ASC X12 837 Coordination of Benefits
  - ASC X12 275 Claims Attachment

- Accepted transactions, such as real-time, batch
- Contract identifier: Special or national contract
- Provider Network(s) HPID(s), if different than health plan's direct network and demographic/contact information
- Carve out(s) HPID(s) and demographic/contact information, including medical, dental, drug, vision, mental health.

Attachment 2

Memorandum

The Secretary of the U.S. Department of Health and Human Services has the authority to adopt a Health Plan ID (HPID) that serves purposes beyond routing transactions, and Congressional intent and sound health policy call for the exercise of that authority

I. Introduction and purpose of this memorandum.

This memorandum addresses a question that has been raised concerning the authority of the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate a Health Plan ID (HPID) whose usage is not limited to routing transactions. This memorandum argues that the use of a robust HPID that serves purposes beyond the mere routing of transactions, such as the AMA's HPID proposal, not only falls squarely within the Secretary's authority under the Patient Protection and Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such usage is much more consistent with Congressional intent and with the regulatory approaches that the Secretary adopted when the National Employer Identification Number (NEIN) and National Provider Identifier (NPI) final rules were promulgated.

The AMA has for three years been studying how the HPID may best be used to achieve the Congressional vision of maximizing efficiencies in the health care system. Based on the AMA's investigation and discussions with participants throughout the health care system, the AMA recommends that the HPID clearly identify (enumerate) each specific health benefit plan (HPID Type 1), as well as each entity which performs a "health plan" function in the standard transactions (HPID Type 2). The current lack of clear identification in the third-party payment system adds enormous unnecessary cost to the health care system, as all parties are forced to resolve ambiguities with manual processes, including telephone calls, faxes, letters, e-mails and appeals. There are billions of dollars of cost savings associated with a robust health plan identifier system that does more than just identify where health plan transactions should be routed.

II. Statutory bases for adoption of an HPID final rule that requires identification of more than just the entity designated to receive health care transactions (the routing address).

A. ACA and HIPAA.

Section 1104(c)(1) of ACA states as follows:

> UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b))) based on the input of the National Committee on Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

Thus, under section 1104(c)(1), the Secretary must promulgate a HPID final rule as more fully described in 42 U.S.C. § 1320d-2(b). 42 U.S.C. § 1320d-2(b)(1) (enacted as part of HIPAA) states as follows:

> (b) Unique health identifiers
>
> (1) In general
>
> The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each *health plan* and health care provider, the Secretary *shall take into account multiple uses* for identifiers and multiple locations and specialty classifications for health care providers.
>
> (Italics added.)

As this statutory quotation indicates, Congress in HIPAA and most recently in ACA mandates that the Secretary, when developing the HPID, take into account the multiple ways in which the HPID may be used. Such statutory language indicates not only that the Secretary has the authority to promulgate an HPID final rule that requires identification in contexts beyond mere routing transactions, but that Congress actually intended that the HPID should require such identification.

III. Regulatory basis for adoption of an HPID final rule that extends beyond mere routing transactions.

A. The comprehensive definition of "health plan" in HIPAA regulations.

1. Comprehensiveness of the definition of "health plan" and current industry and public convention concerning the usage of "health plan."

The definition of "health plan" in the HIPAA regulations is extremely broad and covers virtually every entity that provides or funds health plan benefits. See 45 C.F.R. § 160.103. (See Attachment 3 for the entire definition of "health plan" contained in 45 C.F.R. § 160.103). As currently used in the health care industry specifically and in the public generally, the term "health plan" refers to a broad array of entities and products. For example, the term can refer to a specific health insurance product that an individual or employer purchases, and "health plan" can also mean the national company that sells that product. The term also frequently refers to the intermediaries that perform administrative tasks that health plans would otherwise perform themselves, such as health care claims adjudication.

2. The text of the definition of "health plan" in 45 C.F.R. § 160.103 does not exclude the inclusion of additional products or entities within the definition of "health plan."

Not only is the definition of "health plan" in the HIPAA regulations extremely broad, it is also non-exclusive, meaning that the definition does not preclude the inclusion of additional entities performing key administrative functions that health plans would otherwise have to perform themselves. More specifically, 45 C.F.R. § 160.103 states that "Health plan includes the following, singly or in combination…." The definition of "health plan" also explicitly excludes specific types of entities from the definition of "health plan." However, the products and entities that are typically included within the meaning of "health plan" and that the AMA HPID proposal would seek to identify do not fall under the types of entities that the definition of "health plan" excludes. In short, given the comprehensiveness and inclusiveness of the definition of "health plan," as well as the restrictiveness of that definition's exclusionary language, nothing in the definition of "health plan" suggests that the term "health plan" was intended to exclude products or entities that the term "health plan" generally refers to in public and industry usage. And, as will be discussed in subsequent sections of this memorandum, requiring identification of products and intermediaries performing the administrative functions that health plans would otherwise have to provide themselves greatly advances the efficiency goals that Congress intended to achieve when it mandated promulgation of the HPID and the HIPAA standard health care transactions.

B. Using the HPID to capture information regarding the entities and products generally understood to fall within common meaning of "health plan" is more consistent with the National Provider Identifier (NPI) and National Employer Identifier Number (NEIN) final rules than is an HPID whose use is confined solely to routing transactions.

1. The NEIN final rule was developed to capture and report the most accurate employer identification information.

The overall approach taken in the NEIN and NPI is comprehensiveness and specificity, thereby ensuring that information essential to efficient health care transactions is provided timely, accurately and consistently to the parties involved. For example, in the NEIN final rule, the Centers for Medicare and Medicaid Services (CMS) required that EIN reporting drill down to the highest level of specificity. CMS acknowledged that some employer organizations might have multiple EINs (e.g., when a consolidated group of corporations has an EIN itself but each constituent corporation also has its own EIN). 67 F.R. page 38015. Although it was suggested that a general consolidated group EIN be used across the board in all health care transactions involving the group's constituent corporations, CMS rejected this approach. Instead, CMS required use of the EIN on the employee's W-2, which denotes the employee's direct employer and results in the most specific, accurate identification possible.

2. The NPI final rule is comprehensive and requires identification at its highest level of specificity.

The NPI final rule similarly demonstrates a comprehensive approach that simultaneously ensures accuracy by requiring NPI assignment and use at the highest level of meaningful specificity. The NPI defines the term "health care provider" in very broad terms. For example, "health care provider" includes, but is not limited to: physicians and other individual practitioners; hospitals and other institutional providers; suppliers of durable medical equipment, prosthetics, and orthotics; pharmacies; group practices; and even health maintenance organizations in certain circumstances. When it promulgated the NPI final rule, however, CMS recognized that comprehensiveness itself was not sufficient to achieve the efficiency goals that Congress attempted to achieve when it mandated development of the HIPAA standard transactions. CMS understood that, in a manner analogous to what has already been described above in terms of consolidated group EINs, a covered health care provider organization (e.g., a hospital organization) may itself be composed of component covered health care providers (e.g., a pharmacies, outpatient departments, surgical centers, laboratories, psychiatric units, etc.) 69 F.R. page 3438. In the NPI final rule, when health care services were provided by a component covered health care provider that was itself a separate entity, CMS required that the NPI of that covered health care provider be used and not the more general NPI of the covered health care provider organization to maximize the accuracy of the information concerning the specific health care provider involved in the relevant health care transaction. Id.

IV. The necessity of a robust HPID that is not confined to routing transactions.

Much like the approach CMS took when it promulgated the NPI and NEIN final rules, the AMA proposal would require the HPID to be used in a manner that is both comprehensive and maximizes specify and thus, accuracy. Only a comprehensive HPID that requires highly specific identification of patient-specific benefit plans as well as all entities involved in the health plan administrative processes will be able to automate the extremely complex third-party payment system and thereby foster the kind of efficiency that Congress intended to achieve when it mandated promulgation of the HPID and electronic health care standard transactions.

The third-party payment system has become extremely complex because of the following factors:

> First, the proliferation of administrative intermediaries is one source of complexity in the third-party payment system. It is common for a self-insured employer's health benefit plan to contract with a health insurer to perform administrative services that the self-insured employer's health benefit plan would otherwise be performing itself. That health insurer, in turn, very often subcontracts administrative services to other "intermediary" entities such as pharmacy benefit managers, behavioral health benefit managers, radiology benefit managers, preferred provider networks and/or fee negotiation companies to perform various health plan functions that would otherwise be undertaken by the health insurer in its administrator role.
>
> Second, multiple provider contracts are another source of complexity. For example, the average physician practice contracts with 12 different health insurers simultaneously. Each of these contracts, in turn, may require the physician to participate in up to five commercial products. And each of these products may be tied to a different fee schedule. To add an additional level of complexity, many health care providers also contract with preferred provider networks (PPNs) to provide services, which in turn "rent" their PPN networks to self-insured employers or health insurers or even other PPNs. As a result, health care providers that assume they are "out-of-network" with respect to a patient who presents an ID card with the name of a health insurer with which that the provider does not contract may, in fact, be "in-network" as a result of a contract with a PPO network that has been rented to that health insurer.
>
> Third, all this complexity is magnified simply by the widespread lack of transparency. To efficiently manage a patient's care, a health care provider must know all of the following:
>
> **1) the patient's specific health plan—**what the patient's benefits and deductible, co-payment and co-insurance responsibilities are, and what prior authorization or other health plan requirements apply;
>
> **2) the entity that funds the benefit—**whether the health plan is funded by a self-insured employer, health insurer, or government payer;
>
> **3) the entity that receives transactions—**where to send electronic health care transactions;

4) the entity that administers the benefits—which entity is responsible for administering the health plan, including any benefits that have been "carved out" and delegated to another entity, like a pharmacy benefit manager; and

5) the contracting entity—which entity, if any, holds the direct contract with the health care provider, and which of the fee schedules the health care provider may have contracted for with that entity will apply to the services to be provided to a particular patient.

However, it is rare that all this information is included in the electronic transactions today. Indeed, there is no way that the current "PayerID" used as the routing address can communicate all this information.

As noted above, this current lack of clear identification in the third-party payment system adds enormous unnecessary cost to the health care system, as all parties are forced to resolve these ambiguities with manual processes, including telephone calls, faxes, letters, e-mails and appeals. There are billions of dollars of cost savings associated with a robust health plan identifier system that does more than just identify where health plan transactions should be routed.

V. The AMA proposal for a more robust HPID.

The AMA recommends that the HPID clearly identify (enumerate) each specific health benefit plan (HPID Type 1) as well as each entity that performs a "health plan" function in the standard transactions (HPID Type 2). Each of these entities would receive only one identifier. If an entity performs more than one function in any given transaction that would be indicated by placement of the entity's Type 2 HPID in the appropriate fields in the standard transaction indicating that function.

The entities that need to be identified with a Type 2 HPID include:

1) entities that have responsibility for ***receiving*** standard transactions (for example, the primary, secondary, or tertiary payer; third-party administrator, network pre-pricer or repricer);

2) entities that have responsibility for ***administering*** standard transactions (for example, the health insurer, pharmacy benefit manager or other out-sourced benefit manager, third-party administrator);

3) entities that have responsibility for ***contracting*** directly with health care providers (for example, the health insurer, preferred provider network, *fee negotiation company*); and

4) entities that have responsibility for ***funding*** of the benefit (for example, self-insured employer, health insurer, government payer).

Finally, to enable full automation of the eligibility (ANSI X12 270-271) and claim (ANSI X12 837-835) standard transactions, entities that have responsibility for ***contracting*** directly with health care providers must also disclose which of the health care provider's contracted fee schedules will apply to the services to be provided to a particular patient by disclosing on the eligibility response (ANSI X12 271) and remittance advice (ANSI X12 835) standard transactions an identifier for the specific fee schedule applicable to the transaction. The AMA recommends this be done with a fee schedule identifier following a national standard format, generated by the entity that contracts directly with the health care provider. To be clear, the fee schedule identifier is just an identifier that enables the health care provider to load the appropriate fee schedule, just as the entity that is administering the claims transaction must do to price the claim. The AMA is not proposing that the fee schedules themselves be made public.

With respect to the types of entities that would be required to obtain a Type 2 HPID, the AMA proposal adopts an approach very similar to that taken by CMS in the NPI final rule. In that rule, CMS *required* covered health care provider organizations (e.g., hospitals) to obtain Type 2 NPIs for organizational components that themselves were legally separate covered health care providers, even though the health care organization was already required to have an NPI. See 69 F.R. page 3438. For example, an ambulatory surgery center (ASC) that is a separate legal entity from a hospital must obtain its own NPI if it is a covered health care provider, even if the ASC is a component of that hospital. However, CMS did not *require, but merely permitted,* covered health care provider organizations to

obtain NPIs for so-called “subparts.” In contrast to component-covered health care providers that are legally distinct from their overarching organizations, subparts are *not* separate legal entities from their larger covered health care provider organizations. For example, a psychiatric unit that is not a legally entity distinct from its hospital would constitute a “subpart” of that hospital under the NPI final rule. The NPI final rule would not, therefore, require the hospital to obtain a separate NPI for that unit. The hospital may, however, obtain an NPI for its psychiatric unit if the hospital so chose. Id.

Similarly, under the AMA proposal, organizations performing health plan functions would not be required to obtain a Type 2 HPID for any of their divisions, units or programs that are not separate legal entities but would be permitted to do so if the entity wished to do so for business reasons. For example, a health insurer administering claims processing functions utilizing various processing platforms would not be required to obtain HPIDs for each of those platforms, so long as those platforms were not legal entities distinct from the health insurer but would be permitted to do so if, for example, the health insurer preferred to have claims routed directly to those claims platforms. The AMA proposal would, however, require all legally distinct entities involved in performing health plan functions to obtain their own HPIDs.

VI. Conclusion

The Secretary has the authority under the ACA and HIPAA to promulgate a robust HPID whose purpose is not narrowly confined to routing transactions. Statutory language, regulatory definitions and requirements, and the approach that CMS has taken in previous final rules concerning other national identifiers demonstrate that the Secretary has such authority. Given the complexity of the third-party payment process, only robust identification requirements can achieve the types of efficiencies and significant cost savings to the health care system that Congress intended to achieve when it mandated the promulgation of national identifiers and standard health care transactions.

Attachment 3

45 CFR § 160.103 (Portions defining "health plan")

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 the following, singly or in combination:

(i) A group health plan, as defined in this section.
(ii) A health insurance issuer, as defined in this section.
(iii) An HMO, as defined in this section.
(iv) Part A or Part B of the Medicare program under title XVIII of the Act.
(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, *et seq.*
(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)).
(vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.
(viii) 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.
(ix) The health care program for active military personnel under title 10 of the United States Code.
(x) The veterans health care program under 38 U.S.C. chapter 17.
(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
(xii) The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, *et seq.*
(xiii) The Federal Employees Health Benefits Program under 5 U.S.C. 8902, *et seq.*
(xiv) An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, *et seq.*
(xv) The Medicare+Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w–21 through 1395w–28.
(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
(xvii) 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) *Health plan* excludes:

(i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg–91(c)(1); and
(ii) A government-funded program (other than one listed in paragraph (1)(i)–(xvi) of this definition):
(A) Whose principal purpose is other than providing, or paying the cost of, health care; or
(B) Whose principal activity is:
(1) The direct provision of health care to persons; or
(2) The making of grants to fund the direct provision of health care to persons.

Group health plan (also see definition of health plan in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg–91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or
(2) Is administered by an entity other than the employer that established and maintains the plan.

Health insurance issuer (as defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg–91(b)(2) and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.

The following is an example of possible solutions X12 and the Rules Committee can adopt. Access to the ASC X12N 006020 version is available at: www.wpc-edi.com to identify the enhancements made to accommodate the reporting of the entities serving in health plan roles and the payer-assigned fee schedule identifier.

HPID Recommendation for ASC X12N 005010 271					
Entity	HPID Recommended Information	5010 271 Segment	5010 Loop	5010 Field Description	5010 Field
Primary, secondary or tertiary payer, Third party administrator, network pre-pricer or re-pricer	Entity that is responsible for receiving the claim	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101 = PRP (Primary Payer)
				NM108-Identification Code Qualifier	NM108 = XV (HPID or OEID)
Health insurer, Pharmacy Benefit Manager (PBM) or other outsourced benefit manager, Third party administrator	Entity that is responsible for administering the claim	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101 =PR
				NM108-Identification Code Qualifier	NM108 = XV (HPID or OEID)
	Plan/product type 'description,' not to be confused with the Claim Filing Indicator which is the Plan/Product code[1]. .	EB-SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION	Loop 2110C	EB05-Plan Coverage Description	EB05 = Plan name or product name
Health insurer, Provider Network, Employer	Entity that has the direct contract with the provider	REF-SUBSCRIBER ADDITIONAL IDENTIFICATION	Loop 2100C	REF01-Reference Identification Qualifier	REF01 =CT (Contract Number)
				REF02-Description	REF02 = HPID/OEID
	Fee schedule that applies to the claim	REF-SUBSCRIBER ADDITIONAL IDENTIFICATION	Loop 2100C	REF01-Reference Identification Qualifier	REF01=CT (Contract Number)
				REF02-Reference Identification	REF02= possibly require fee schedule number embedded in Contract Number
Health insurer, Government payer, Self insured employer	Entity that is responsible for funding the benefit	NM1-SUBSCRIBER BENEFIT RELATED ENTITY NAME	Loop 2120C	NM101-Entity Identifier Code	NM101=P5
				NM108-Identification Code Qualifier	NM108 = XV (HPID)

[1] The 271 Plan/Product list should be 'synched' with the 835.

The following is an example of possible solutions X12 and the Rules Committee can consider. Note: These loops are not currently all designed for the information specified. This is an illustration of the type of usage that X12N and any Usage Rules entity would need to create rules to effectively utilize the HPID for these functions. We encourage HHS to access the ASC X12N 006020 version from www.wpc-edi.com to identify the enhancements made to the ASC X12N 006020 version to accommodate the reporting of the entities serving in health plan roles and the payer-assigned fee schedule identifier.

HPID Recommendation for ASC X12 005010 835					
Entity	HPID Recommended Information	5010 Segment	5010 Loop	5010 Field Description	5010 Field
Health insurer, Pharmacy Benefit Manager (PBM) or other outsourced benefit manager, third party administrator	Entity that is responsible for administering the claim	N1-PAYER IDENTIFICATION	Loop 1000A	N103-Identification Code Qualifier	N103 = XV
				N104-Identification Code	N104 = NHPI
Health insurer, Government payer, Self insured employer	Entity that is responsible for funding the benefit	REF-ADDITIONAL PAYER IDENTIFICATION	Loop 1000A	REF01-Reference Identification Qualifier	REF01 = EO
				REF02-Reference Identification	REF02 = HPID
Health insurer, Provider Network, Employer	Entity that has the direct contract with the provider	REF-OTHER CLAIM IDENTIFICATION RELATED	Loop 2100	REF01-Reference Identification Qualifier	REF01 = CE
	Fee schedule that applies to the claim			REF02-Reference Identification	REF04-01 = HPID
	Plan/product type 'description,' not to be confused with the Claim Filing Indicator which is the Plan/Product code. The X12 271 Plan/Product list should be 'synched' with the 835.				