National Health Plan Identifier White Paper

Prepared by the American Medical Association (AMA) Practice Management Center (PMC)

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As adopted in 1996, the Health Insurance Portability and Accountability Act (HIPAA) included a chapter entitled "Administrative Simplification," designed to encourage transmission of health care transaction data electronically in order to bring efficiency and cost savings to the administrative practices of health care. The HIPAA regulations relevant to administrative simplification include four interlocking components: (1) Privacy; (2) Security; (3) Unique Identifiers; and (4) Uniform Electronic Transactions and Code Sets. This paper focuses on the third component: unique identifiers.[1] HIPAA requires the assignment of unique health identifiers for each individual, employer, health plan and health care provider in the health care system. To date, the unique identifiers for employers and health care providers have been implemented. The development of a unique patient identifier standard for each patient has not occurred due to privacy concerns. The National Health Plan Identifier (NHPI) has not been adopted either. However, the NHPI is needed in the HIPAA standard transactions to achieve the true benefits of automated administrative transactions and to support the emerging trend towards real-time adjudication of claims. **The AMA urges the Department of Health and Human Services' (HHS) immediate action on the NHPI and provides the following recommendation for consideration by all stakeholders in the claims processing and payment process.**

The NHPI is viewed by many as a crucial step toward one-stop, automated billing. To achieve this goal, the NHPI must provide for the clear identification of all the entities involved in the claims payment process, including:

1. the entity with primary financial responsibility for paying the claim;
2. the entity responsible for administering the claim;
3. the entity that has the direct contract with the health care provider;
4. the specific fee schedule that applies to the claim;
5. the specific plan/product type;
6. the location where the claim is to be sent; and
7. any secondary or tertiary payers.

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[1] This white paper expands on the previous Administrative Simplification White Papers which summarize the AMA's recommendations to eliminate significant administrative waste from the health care system by simplifying and standardizing the current health care billing and payment process. Visit www.ama-assn.org/go/simplify to access the "Standardization of the Claims Process" and the "Standardization of CPT codes, guidelines and conventions" white papers.

With payer responsibilities clear at the outset, the burden on patients, physicians, other health care providers and payers for determining the parties with financial responsibility is eliminated, and ambiguity regarding payment is greatly reduced. The Medical Group Management Association has estimated the savings to the industry from this initiative to be approximately $8.8 billion dollars over the next 10 years.

A significant discussion of the NHPI occurred in the late 1990s and is captured in a paper titled, "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper" dated March 11, 1998.[2] This paper provides a good overview of the challenges of the claims billing, payment and claims reconciliation process without the establishment of a NHPI. The AMA, through the National Uniform Claim Committee, supported the NHPI proposal contained in that 1998 white paper. However, changes in the health care environment since the late 1990s and lessons learned from the enumeration and implementation of the National Provider Identifier (NPI) have led the AMA to revisit this issue. We now suggest a new approach which we believe will better provide the information necessary for streamlining the claims payment and reconciliation process, while at the same time building on the existing enumerators for health plans and their agents, thus reducing the potential disruption of NHPI implementation. We also recommend a two-phase approach to adopting a NHPI. Phase I would prioritize the adoption of a unique identifier for private sector health plans and private payers administering public plans. The adoption of a unique identifier for governmental entities would occur in Phase II and requires additional study.

Challenges with the lack of a NHPI

The issues with the lack of a National Health Plan Identifier listed in the 1998 discussion paper mentioned above have only become more complex with the proliferation of different types of health insurance products, benefit plans and delivery vehicles, including high deductible health plans, health savings accounts, discount cards and ever-evolving relationships between payers and their agents, including third-party administrators and rental network preferred provider organizations (PPO). This increased complexity has increased the challenges to automating the claims payment and reconciliation process. It is not only necessary to ensure that transactions are routed correctly and in a timely way, but it is also critical that all the entities associated with the claims billing and payment process and the specific fee schedule applicable to each claim are clearly identified.

To achieve the goal of a fully automated claims payment and reconciliation cycle, all relevant information concerning the payer, the payer's agents and the fee schedule amount must be transmitted on all relevant transactions in unambiguous terms. Today, physicians are unable to clearly identify:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim;

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[2] Visit http://www.payorid.com/Medicare/HIPAA.htm to access the "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper".

4. The fee schedule that applies to the claim;
5. The specific plan/product type;
6. The location where the claim is to be sent; or
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim.

Without a standard method of identification of these variables, patients, physicians and other health care providers must either contact the plan directly and request the information before patient treatment is delivered, and/or be forced to contact the plan after payment is rendered to ascertain if the contractual agreement was fulfilled. Ambiguity and manual intervention contributes to higher costs for everyone.

Coordination of benefits

The NHPI will also enable the automation of the coordination of benefits (COB) process. COB is the process of coordinating the adjudication of a claim between two or more payers that both have financial responsibility for health services being rendered. The adoption of a NHPI to include provider networks, third-party administrators (TPAs) and other entities involved in a claim transaction would facilitate identification of the various payers. Further, because the process of identifying secondary payers is not automated, physicians and other health care providers must often generate paper claims, further contributing to higher transaction costs and increased risk of error. NHPI will facilitate the generation of claims automatically to secondary payers or a Medicare supplemental plan, reducing the burden on the patient or beneficiary. A robust, standard NHPI will ensure that a physician or other health care provider using a clearinghouse will always have access to all relevant payer IDs, whether they are primary, secondary or tertiary.

This example of cost savings that could be realized is not isolated to the commercial health insurers. Automating a Medicare patient's COB is one example of how the NHPI could simplify the routing of multiple transactions, including coordination of benefit issues, many of them currently routed manually by beneficiaries and physicians. "By law, Medicare is not the primary health plan (1) when certain Medicare beneficiaries are also covered under employer group health plans or (2) when the illness or injury is covered under liability or no-fault insurance or workers' compensation. Currently, it is difficult to identify exactly what other coverage a Medicare beneficiary has, and millions of Medicare dollars are spent for care that is the primary responsibility of another health plan. Use of an NHPI for each health plan would reduce inappropriate expenditure of funds and expensive recovery efforts. A unique NHPI would also assist Medicare in transferring claims for Medicare beneficiaries covered by Medigap policies and in transmitting complementary claims to and from other health plans. The NHPI would supply the correct electronic address when Medicare needs to send a crossover claim electronically to another health plan."[3]

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[3] "National Health Plan Identifier: The Establishment of a Standard for a National Health Plan Identifier Issue Paper" visit www.payorid.com/Medicare/HIPAA.htm to access.

For all the forgoing reasons, the increased efficiencies and costs savings that can be realized by all stakeholders through the adoption of a robust NHPI would be significant.

Lessons learned from implementation of previous national identifier standards

In developing this recommendation, the AMA considered the lessons learned from the implementation of both the Employer Identifier and the NPI standards.

The employer identifier standard, published in 2002, adopts the employer's tax ID number or Employer Identification Number (EIN) as the standard for electronic transactions. This was an established number, and no separate sign-up, enumeration or enumerator was required. The transition to the EIN was quite seamless.

On the other hand, the NPI was a newly created unique identification number for HIPAA-covered health care providers. It required every health care provider in the country to apply to receive at least one new identification (ID) number, and many health care professionals had to get at least two—one to identify themselves as individuals and one to identify themselves as a medical practice. It also required the establishment of a new database, the National Plan and Provider Enumeration System (NPPES) to house the identifiers and the data associated with each number as well as a registry, which contains the subset of the overall information available to the public. The transition to the newly created NPI was wrought with challenges for all stakeholders. The implementation of the NPI caused great emotional and financial turmoil for physicians nationwide, and the implementation cost was much greater than ever anticipated for all stakeholders.

This experience strongly suggests that existing identifiers should be used whenever feasible. This eliminates the challenges of: (1) getting entities to apply for a new identifier; (2) getting the entire industry to recognize an entirely unfamiliar number; and (3) maintaining a whole new directory of these new numbers.

Enumeration strategy

Appropriate enumeration of health plans and their products has been a source of ongoing debate. One of the main points of contention is the issue of "sub-parts." (This is similar to the issues faced with adoption of the NPI—the difficulty of enumerating the appropriate sub-parts of a provider organization.) With the NHPI, the challenge is how best to enumerate individual health plans—at the corporate level, at the plan "type" level (e.g. HMO, PPO, indemnity, dental, etc.), product level or other level.

If enumerated at the plan "product" level, for example, the NHPI could encompass tens of thousands of numbers. However, plan products change every year, and new numbers would need to be issued on an ongoing basis.

A simpler solution is to enumerate health plans and their agents at the entity level, and use other fields in the X12 5010 271 eligibility benefit response and 835 electronic remittance advice

electronic standards to correctly identify the applicable product and contract. For example, the "Claim Filing Indicator Code" field can be used to indicate the product type. If there is more than one fee schedule that could apply for the same "Claim Filing Indicator Code," then the "Class of Contract" field can be completed using a text string description that ties to the applicable fee schedule, such as a Medicare Advantage Gold or specific rental network PPO.

Given the plethora of potential claims billing and payment scenarios—including the added complexity of rental network PPOs—payment transparency and accuracy can only occur if the following information is clearly identified on the X12 271 eligibility and 835 electronic remittance advice:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim;
4. The fee schedule that applies to the claim;
5. The specific plan/product type;
6. The location where the claim is to be sent; and
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim.

Clear identification of each entity, plan/product type and the specific fee schedule involved in the determination of the ultimate patient benefit and claim payment will result in transparency gains that will benefit patients, payers, and physicians and other health care providers, as well as contribute to a decrease in health care costs for the entire industry. The following recommendation is aimed at simplifying the identification of the above information.

Simplified approach for determining an NHPI for commercial payers

The AMA recommends the consideration of the following NHPI approach:

- Use the IRS health plan identifier (Employer Identification Number [EIN] followed by three-digit plan type), or other applicable IRS identifier, similar to the employer identifier standard, for each of the entities set forth above;

- Use a Global Unique Identifier (GUID), generated by the entity with the direct contract with the health care provider or a consistent industry standard unique identifier, following that entity's IRS identifier, to specify the applicable fee schedule; and

- Use the Claim Filing Indicator Code, coupled with the Class of Contract Code as necessary, to identify the product type.

After reviewing the pending 5010 X12 835 electronic remittance advice, the AMA determined that the IRS identifier could be used as an enumerator for several of the transaction fields, specifically, elements 1, 2, 3 and 7 listed above:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim; and
7. Any applicable secondary or tertiary payers who may have financial responsibility for all or part of the claim;

With respect to item 4, identification of the fee schedule that applies to the claim, we believe the best solution would be for each entity that contracts with health care providers to generate a GUID or a consistent industry standard unique identifier for each contracted fee schedule. As we understand it, health plans typically generate a fee schedule identifier now, so moving to a uniform fee schedule identifier should not be too burdensome, particularly given the dramatic efficiency to be gained in automated claims reconciliation and first-pass pay accuracy. Not only would such an identifier virtually eliminate disputes between payers and health care providers over which fee schedule should apply to the claim, but it would also provide an easy way for providers to verify the accuracy of their contracts and upload their fee schedules into their practice management systems. Item 5, identification of the specific plan type, would require completion of the Claim Filing Indicator Code, as well as a response in the Class of Contract field when a disclosed fee schedule pertains to more than one product.

Finally, the best way to address item 6, the location where the claim is to be sent, remains open. One option would be to establish a plan registry similar to the NPI registry that contains both a physical mailing address and an electronic address for the IRS identifier of each entity with the potential to be included in the field indicating the entity responsible for the administration of the claim. Where such entities have more than one location where claims are to be sent, these entities could ensure the correct addresses are listed by place of service zip code, Claim Filing Indicator Code or even Class of Contract Code to the extent these might be relevant.

Currently, clearinghouses and practice management systems have their own unique health plan identifiers that could easily be replaced with the IRS identifiers. In fact, the newest version of the HIPAA standard transactions being implemented now, Version 5010, has already provided specific guidance for using the EIN in certain fields of the transactions. After reviewing the Technical Report 3s (TR3) for each HIPAA transaction, our recommendations for the NHPI are as follows:

NHPI recommendation			
NHPI recommended information	**Field content**	**5010 segment**	**5010 field**
Entity that is financially responsible for payment	Use EIN plus 3 digits for plan type	BPR-FINANCIAL INFORMATION	Originating Company Identifier
Entity that is responsible for administering the claim	Use EIN	N1-PAYER IDENTIFICATION	Identification Code
Entity that has the direct contract with the provider	Use EIN	REF-OTHER CLAIM IDENTIFICATION RELATED	Reference Identification
Fee schedule that applies to the claim	Create a “Fee Schedule ID” GUID or a consistent industry standard unique identifier; can be reported in the Claim Filing Indicator Code field in the 835 (Electronic Remittance Advice) following the EIN of the entity that has the direct contract with the provider		
Plan/product type “description,” not to be confused with the Claim Filing Indicator which is the Plan/Product code. The 271 Plan/Product list should be “synched” with the 835.	Text string description reported in the Class of Contract field in the 835 (Electronic Remittance Advice) should be required when the Claim Filing Indicator Code is associated with more than one product/fee schedule.		
Secondary or tertiary entities that may be financially responsible for payment	Use EIN plus 3 digits for plan type	REF-ADDITIONAL PAYER IDENTIFICATION	Reference Identification
Location of where the claim is sent	Use Uniform Resource Locator to identify where the claim should be sent for processing.	PER-PAYER TECHNICAL CONTACT INFORMATION	Communication Number

Implementation considerations

Implementation timeframes

HIPAA mandates a 24-month implementation period for providers, clearinghouses and most health plans after the effective date of a new standard is established. We believe that the process of developing and publishing a Notice of Proposed Rulemaking and a final rule should be expedited in order for the industry to begin taking advantage of the NHPI administrative simplification benefits. The simultaneous implementation of the HIPAA 5010 (October 1, 2012

implementation date) electronic transactions and the NHPI should be seriously considered as this could reduce the number of practice management system software upgrade requirements. We would strongly encourage all health plans to enumerate and disseminate their NHPIs prior to the compliance date of the NHPI final rule. **The AMA encourages the HHS Secretary to publish a final rule to create an implementation date of October 1, 2012.**

Transition phase

It will be important to carefully consider how best to handle running systems using any health plan, clearinghouse or practice management system existing legacy numbers with the NHPI, as running dual identification numbers became quite cumbersome during the transition to the NPI despite the fact that it allowed for interim steps to implementation. The Centers for Medicare and Medicaid Services (CMS) is strongly encouraged to work closely with all the key stakeholders to ensure feedback is sought at key junctures along the way to NHPI 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 NHPIs.

Infrastructure and required modifications

Because the NPPES was developed specifically for assigning and housing identifiers, CMS should not have to build another database to house the NHPIs and electronic claim submission addresses and mailing addresses, if CMS wishes to serve as a clearinghouse for the IRS health plan identifiers set forth above. However, the EIN and IRS health plan identifiers are currently public, and the GUIDs associated with specific fee schedules would be relevant only to the contracting health care providers who would receive these directly from the contracting agent, so it is possible that only the identifiers associated with claims' submission addresses would need to be included. In addition, even if a NHPI was established tomorrow, there are fields in the existing HIPAA standard transactions where these could be used, so the standards do not need modification prior to implementation.

Despite this existing infrastructure, a number of lessons were learned during the NPI enumeration process that should be taken into consideration as plans for NHPI implementation continue:

- Every effort must be made to ensure physician and other health care provider payment interruptions are averted. Specifically, clear and flexible guidance must be created and shared widely for advance payments (i.e., to date, despite numerous repeated requests of Medicare, only a handful of contractors have any information on their Web sites, and many customer service agents continue to remain unaware of this option despite an untold number of physicians who experienced cash flow problems that lasted months during the NPI transition).

- Ample time and clear messaging from CMS is needed in order to ensure a smooth transition.

- CMS 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.

- Interim steps to implementation will be helpful.

- Running dual identification numbers, NHPI 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.

- Standardization/normalization across all payers/clearinghouses is critical during the transition period.

- Industry access to the NHPI database will be critical to implementation.

Conclusion

The Secretary of HHS should expedite the adoption of a NHPI. Clear identification of each health plan, each health plan contractor involved in the claims process and the specific fee schedule applicable to each claim will benefit patients, payers and health care providers. With the informed experience gained from the implementation of the HIPAA employer and provider unique identifiers, including the use of existing identifiers to the extent feasible, the disruption from this initiative can be minimized.