



# AMERICAN BENEFITS COUNCIL

July 28, 2015

*Submitted electronically via <http://www.regulations.gov>*

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-0026-NC  
P.O. Box 8013, Baltimore, MD 21244-8013

**Re: Request for Information Regarding the Requirements for the Health Plan Identifier  
[CMS-0026-NC]**

Dear Sir or Madam:

I write on behalf of the American Benefits Council (“Council”) to provide comment in connection with the Request for Information (“RFI”) Regarding the Requirements for the Health Plan Identifier (“HPID”), published in the Federal Register on May 29, 2015, by the Department of Health and Human Services (“the Department”) (80 Fed. Reg. 30646). The final HPID rule was published in the Federal Register on September 5, 2012, (77 Fed. Reg. 54664).

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council’s members either sponsor directly or provide services to health and retirement plans that cover more than 100 million Americans.

## **Background**

The RFI requested comments on the following:

- (1) The HPID enumeration structure outlined in the HPID final rule, including the use of CHP/SHP and OEID concepts.
- (2) The use of the HPID in HIPAA transactions in conjunction with the Payer ID.
- (3) Whether changes to the nation’s health care system, since the issuance of the HPID final rule published September 5, 2012, have altered our perspective about the function of the HPID.

The Council appreciates the opportunity to comment on these final rules and whether there is still a business or policy need for an HPID in light of other identifiers already in use.

### **Council Comments**

In a letter to the Secretary on September 24, 2014, the National Committee on Vital and Health Statistics (“NCVHS”) reported that “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.” The NCVHS letter further indicated that those who testified “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.”<sup>1</sup>

The NCVHS cited testimony regarding:

- 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.

In consideration of this testimony, the NCVHS recommended that “HHS should rectify in rulemaking that all covered entities (current and future health plans, providers, and clearinghouses, and their business associates) will not use the HPID in administrative transactions, and that the current payer ID will not be replaced with the HPID.”

**The Council shares the significant concerns expressed in the NCVHS letter and strongly supports its recommendation to eliminate the HPID in administrative transactions.** We urge that the Department not proceed with implementation.

There is ongoing confusion among employer plan sponsors as to why the HPID is needed and, if required, how the HPID would or should be used. HIPAA-covered entities are able to sufficiently identify the payer and any other information needed to process standard transactions under the existing Payer ID framework. While the HPID may have been a useful identifier when the standard transaction requirements were first introduced, it is no longer

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<sup>1</sup> National Committee on Vital and Health Statistics Letter to the Secretary, [Findings from the June 2014 NCVHS Hearing on Coordination of Benefits, Health Plan Identifier \(HPID\), and ICD-10 Delay](#). September 23, 2014.

necessary and would serve as an impediment to the uniform transmission of information, undermining the very goal of the administrative simplification rules.

If the Department, however, does move forward with the HPID rule despite the NCVHS recommendations, we request that the following concerns be addressed.

*The HPID rules should not apply to plans that do not conduct standard transactions.* The purpose of having an HPID is so that health plans may have a uniform identifier to use in HIPAA standard transactions. There are some entities that are considered covered entity “health plans” under the HIPAA privacy rules but that would not be in a position to ever conduct standard transactions. For example, employee assistance programs are ancillary benefits that typically provide services directly to an individual. There are no “claims” and usually no separate premiums – these benefits typically are employer-pay-all. Similarly, account-based plans, such as flexible spending accounts, health savings accounts, and health reimbursement arrangements reimburse individuals for certain medical expenses. They do not conduct standard transactions between two HIPAA covered entities.

*Eliminate the concept of a “controlling health plan” or “sub health plan.”* Neither the HIPAA portability statute nor the applicable sections of the Affordable Care Act use the term “controlling health plan” or “sub health plan.” These terms were first introduced in the proposed HPID rules.<sup>2</sup> There is significant confusion in the employer community as to how to determine when one plan “controls” or “is controlled” by another. We strongly recommend they be eliminated.

*Allow flexibility to obtain one HPID or multiple HPIDs.* Some employers combine benefit options into one global benefit package, while others view their benefit options separately. Given the myriad of structures of employer health plans, any HPID requirement should provide employers the flexibility to obtain one HPID for all health plan benefits that the employer sponsors or separate HPIDs for each separate benefit option (or some combination).

*Simplify the process for obtaining HPID and allow sufficient time for testing and compliance.* Many Council member plan sponsors and service providers unsuccessfully attempted to obtain an HPID before the requirement was delayed. The process to obtain an HPID was overly cumbersome and confusing. In some cases, plans only could advance so far in the process before the system shut down and they had to re-start. In other cases, they did not have the necessary information to complete the form (e.g., Payer ID or NAIC number), and the screens would not let them continue. If the Department moves forward with the HPID rule, we strongly urge that the Department not proceed with a process for obtaining an HPID until it has performed thorough end-to-end testing.

In addition, any future requirements should provide sufficient time for health plans to implement. Health plans are faced with unprecedented new compliance obligations in the

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<sup>2</sup> 77 Fed. Reg. 22950 (April 17, 2012).

wake of the Affordable Care Act. These include new and complex employer reporting obligations under Internal Revenue Code sections 6055 and 6056, effective for the 2015 tax year, that are currently requiring employers to expend substantial time and resources to implement.

**Proposed HIPAA Certification Rule**

The Council also recommends that any action on the proposed HIPAA certification rule should be delayed to allow sufficient time to evaluate requirements and any changes to the HPID rule.

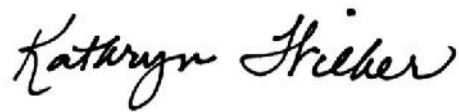
On January 2, 2014, the Department published a proposed regulation requiring health plans to certify compliance with certain HIPAA standard transactions.<sup>3</sup> The proposed certification regulation uses some of the same concepts found in the HPID rule, including the definition of “controlling health plan.” On April 1, 2014, the Council provided comments on the proposed certification rule and expressed a range of concerns regarding how the requirements would apply to self-funded group health plans. The Council noted that it was unclear how these entities would certify compliance where they were not the party that conducted standard transactions.

Due to the many questions on the proposed certification rule, many of them the same questions that apply to the HPID rule, we strongly urge the Department to also revisit its rulemaking on the certification process and request additional information from health plans and other stakeholders before moving forward.

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Thank you for considering these comments submitted in response to the RFI. If you have any questions or would like to discuss these comments further, please contact me at (202) 289-6700.

Sincerely,



Kathryn Wilber  
Senior Counsel,  
Health Policy

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<sup>3</sup> 79 Fed. Reg. 298 (January 2, 2014).