

## **Supporting Statement for Health Plan Identifier, Other Entity Identifier, and Change to National Provider Identifier Requirements in 45 CFR Part 162**

### **Background**

The Affordable Care Act (ACA) enacted on March 23, 2010 includes sections related to administrative simplification (Sec. 1104) and standards for financial and administrative transactions (Sec. 10109). These provisions are directly connected to those under the Health Insurance and Portability Act of 1996 (HIPAA) with respect to the adoption and use of standards for certain health care transactions. Section 1104 of the ACA requires the Secretary of Health and Human Service (HHS) to establish a unique health plan identifier 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 no later than October 1, 2012.

The Affordable Care Act builds on the existing requirement in Section 1173(b) of the Social Security Act (SSA) to adopt unique health identifiers. It specifically states that 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.”

Health plan is defined in Section 1171(5) of the SSA. 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 Public Health Service Act, 42 U.S.C 300gg-91(a)(2)).

(1) Health plan includes the following, singly or in combination:

- (i) A group health plan.
- (ii) A health insurance issuer.
- (iii) An HMO.
- (iv) Parts A, B, or C of the Medicare program.
- (v) The Medicaid program.

- (vi) An issuer of a Medicare supplemental policy.
- (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.
- (x) The veterans health care program.
- (xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
- (xii) The Indian Health Service program under the Indian Health Care Improvement Act.
- (xiii) The Federal Employees Health Benefits Program.

The definition of health plan is expanded in 45 CFR 160.103 to include the following.

**Regulatory (§160.103) Definition of Health Plan**

- (xiv) An approved State child health plan, providing benefits for child health assistance.
- (xv) The Medicare+Choice program.
- (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

The use of this standard identifier will promote efficiency, simplify administrative tasks, encourage faster automation of health care transactions, reduce administrative functions, and improve accuracy.

**B. Justification**

## **1. Need and Legal Basis**

### **Purpose and Background**

This proposed regulation associated with this information collection request [CMS-0040-P; RIN 0938-AQ13] proposes the adoption of the standard for a national unique health plan identifier (HPID), the adoption of a data element that will serve as an other entity identifier (OEID). In addition, this rule proposes a new National Provider Identifier (NPI) requirement.

#### **HPID**

This proposed rule would implement section 1104 of the of the Patient Protection and Affordable Care Act (hereinafter referred to as the Affordable Care Act) by establishing new requirements for administrative transactions that would improve the utility of the existing Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions and reduce administrative burden and costs.

Currently, health plans and other entities that perform health plan functions, such as third party administrators and clearinghouses, are identified in the standard transactions using multiple identifiers that differ in length and format. Health care providers are frustrated by the following problems associated with the lack of a standard identifier: the routing of transactions; rejected transactions due to insurance identification errors; difficulty determining patient eligibility; and challenges resolving errors identifying the health plan during claims processing.

The adoption of the HPID and the OEID will increase standardization within the HIPAA standard transactions and provide a platform for other regulatory and industry initiatives. Their adoption will allow for a higher level of automation for provider offices, particularly for provider processing of billing and insurance related tasks, eligibility responses from the health plans and

remittance advice that describes health care claim payments.

## **NPI**

This proposed rule supports the statutory purpose of the Administrative Simplification provisions of HIPAA “to improve the Medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of uniform standards and requirements for the electronic transmission of certain health information and to reduce the clerical burden on patients, health care providers, and health plans.” Section 261 of the Act (42 U.S.C. 1320d note). It also supports section 1173(a)(3) of the Act, which requires the transaction standards adopted by the Secretary to accommodate the needs of different types of health care providers.

In January 2004, we published a final rule in which the Secretary adopted the National Provider Identifier (NPI) as the standard unique health care provider identifier and the requirements for obtaining and using the NPI. Since that time, pharmacies are encountering situations where the NPI of a prescribing health care provider needs to be included in the pharmacy claim, but the prescribing health care provider does not have an NPI or has not disclosed it. This situation has become notably problematic in the Medicare Part D program. This new NPI requirement seeks to address this issue.

## **2. Information Users**

Health plans, health care clearinghouses, and health care providers will be required to use the the health plan identifiers to identify health plans in the standard transactions.

## **3. Improved Information Technology**

The benefits of the electronic transfer of this information are a substantial reduction in handling and processing time, the elimination of the inefficiencies associated with the handling of paper documents, a reduction in administrative burden, lower operating costs, and improved data quality and standardization. Enumerating each applicable entity and including applicable information in the HPID directory database should enable many provider and individual questions that arise in the course of processing transactions to be addressed.

#### **4. Duplication of Similar Information**

These standards will replace through standardization, rather than duplicate, existing health plan identification enumeration systems which were inconsistent and often proprietary.

#### **5. Small Businesses**

Small businesses are not significantly affected by this collection. We expect that this proposed rule would have a modest impact on a substantial number of small entities.

#### **6. Less Frequent Collection**

Enumeration of health plans is required under law, in order for health plan entities to conduct business. If not enumerated, a health plan will not be allowed to conduct business. After the initial enumeration, an annual validation is the minimum standard deemed acceptable to assure that the information that is collected is accurate in order to carry out administrative and financial health transactions.

#### **7. Special Circumstances**

There are no applicable special circumstances.

#### **8. Federal Register Notice/Outside Consultation**

The notice of proposed rulemaking (CMS-0040-P) published in the *Federal Register* on April 17, 2012 (77 FR 22950).

In the course of the development of the updated transaction standards, exhaustive consultations took place with a number of outside organizations, including those with whom consultation is required by Subtitle F. These include the National Uniform Billing Committee, the National Uniform Claim Committee, Workgroup for Electronic Data Interchange, the American Dental Association, the National Council for Prescription Drug Programs, and the National Committee on Vital and Health Statistics. We have obtained endorsement for the proposed enumeration system from each of these organizations.

#### **9. Payment/Gift To Respondent**

There will be no payments/gifts to respondents.

#### **10. Confidentiality**

There is no information of a proprietary or confidential nature required for the issuance of the Health Plan identification number. The purpose of the required enumeration is to improve the efficiencies and accuracy of electronic healthcare transactions.

#### **11. Sensitive Questions**

No information will be collected on sexual behavior and attitudes, religious beliefs, and other matters commonly considered private.

#### **12. Burden Estimate (Total Hours & Wages)**

##### **HPID**

In order to apply for an HPID or OEID, there is an initial onetime requirement for information burden on health plans and other entities that elect to apply for an OEID. In addition, health plans and other entities may need to provide updates to information.

Under this proposed rule, a Controlling Health Plan “CHP”, as defined in 45 CFR 162.103, will have to obtain an HPID from a centralized electronic Enumeration System. A Sub Health Plan “SHP”, as defined in 45 CFR 162.103, would be eligible but not required to obtain an

HPID. If a SHP obtains an HPID, it would apply either directly to the Enumeration System or its CHP would apply to the Enumeration System on its behalf. Other entities may apply to obtain an OEID from the Enumeration System. Health plans that obtain an HPID and other entities that obtain an OEID would have to communicate any changes to their information to the Enumeration System within 30 days of the change. A covered entity must use an HPID to identify a health plan in a standard transaction.

We estimate that there will be up to 15,000 entities that will be required to, or will elect to, obtain an HPID or OEID. We based this number on the following data:

<b>Type of Entity</b>	<b>Number of Entities</b>
Self insured group health plans	12,000*
Health insurance issuers, individuals and group health markets, HMOs, including companies offering Medicaid managed care	1,827**
Medicare, Veterans Health Administration (VHA), Indian Health Service (IHS), TRICARE, and State Medicaid programs	60
Clearinghouses and Transaction Vendors	162***
Third Party Administrators	750 ****
<b>Total</b>	<b>~ 15,000</b>

\*"Report to Congress: Annual Report on Self –Insured Group Health Plans," by Hilda L. Solis, Secretary of Labor, March 2011.

\*\* Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule <http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf>, based on a study by Gartner.

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\*\*\*\* Summary of Benefits and Coverage and the Uniform Glossary; Notice of Proposed Rulemaking <http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf>.

Note that the number of health plans that will be required to obtain, or have the option to obtain an HPID is considerably larger than the number of health plans for which we analyze in section V. of this proposed rule. This is because self-insured health plans are required to obtain

HPIDs if they meet the requirements of a Controlling health plan under this proposed rule.

However, we assume that very few self-insured group health plans conduct standard transactions themselves; rather, they typically contract with third party administrators or insurance issuers to administer the plans. Therefore, there will be significantly fewer health plans that use HPIDs in standard transactions than health plans that are required to obtain HPIDs, and only health plans that use the HPIDs in standard transactions will have direct costs and benefits.

To comply with these requirements, health plans will complete an HPID enrollment application/update form online through the Enumeration System. This online form serves two purposes: It enables a health plan to apply for an HPID and to provide updates to the Enumeration System.

Other entities electing to apply for an OEID must complete an application/update form online through the Enumeration System. The online form serves two purposes: it enables other entities to apply for an OEID and to provide updates to the Enumeration System.

Most health plans and other entities will not have to furnish updates in a given year. However, lacking any available data on rate of change, we elected to base our assumptions on information in the Medicare program that approximately 12.6 percent of health care providers provide updates in a calendar year. We anticipate this figure would be on the high end for health plans and other entities. Applying this assumption, we can expect that 1,764 health plans will need to complete and submit the HPID application update form in a given year.

Applying for HPID or OEID is a one-time burden. In future years, this burden would apply only to new health plans and as an option for other entities as described in the section IV. of this proposed rule. From 2013 to 2018, industry trends indicate that the number of health



plans will remain constant, or even decrease.<sup>1</sup> Therefore, our calculations reflect that there will be no statistically significant growth in the number of health plans or other entities and we calculate zero growth in new applications.

We estimate it will take 30 minutes to complete the application form and use an hourly labor rate of approximately \$23/hour, the average wage reported for professional and business and services sector, based on data from the Department of Labor, Bureau of Labor Statistics, June 2010, "Average hourly and weekly earnings of production and nonsupervisory employees (1) on private nonfarm payrolls." (<ftp://ftp.bls.gov/pub/suppl/empsit.ceseeb11.txt>). This represents a unit cost of \$11.50 per application for both HPID and OEID.

Because our initial estimate for the number of applications for OEID is small (162 Clearinghouses and Transaction Vendors + 750 Third party administrators = ~ 1,000) and the costs negligible, we do not include separate calculations. We have elected instead to offer the unit cost figure as a baseline if commenters demonstrate that the universe of applications for OEID is likely to expand significantly.

We are proposing to put an additional requirement on covered organization health care providers that have as members, employees, or contracts with individual health care providers who are not a covered entities and who are prescribers. By 180 days after the effective date of the final rule, such organizations must require such health care provider to: (1) obtain, by application if necessary, an NPI from the National Plan and Provider Enumeration System

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<sup>1</sup> Robinson, James C., "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, 23, no.6 (2004):11-24

"Private Health insurance: Research on Competition in the Insurance Industry," United States Government Accountability Office (GAO), July 31, 2009 (GAO-09-864R)

American Medical Association, "Competition in Health Insurance: A Comprehensive Study of US Markets," 2008 and 2009.

(NPPES); (2) to the extent the prescriber writes a prescription while acting within the scope of the prescriber's relationship with the organization, disclose his or her NPI, upon request to any entity that needs the NPI to identify the prescriber in a standard transaction;

The burden associated with the addition to the requirements of §162.410 as discussed in this proposed rule is the initial one-time burden on prescribers who do not already have an NPI, who have a relationship with a covered health care provider, and who must be identified in a standard transaction, to apply for an NPI and later to furnish updates, as necessary. We estimate that there are approximately 1.4 million prescribers in the United States and that approximately 160,000 of them do not have an NPI. It is these prescribers who would have to obtain an NPI if this rule is finalized as proposed. Based on the estimations in the NPI final rule, we estimate that it will take 20 minutes to complete an application for an NPI and use an hourly labor rate of approximately \$23/hour, the average wage reported for professional and business and services sector, based on data from the Department of Labor, Bureau of Labor Statistics, June 2011, "Average hourly and weekly earnings of production and nonsupervisory employees (1) on private nonfarm payrolls." (<ftp://ftp.bls.gov/pub/suppl/empsit.ceseeb11.txt>). Additionally, we have calculated an increase of 3 percent for labor costs for each of the years 2013 through 2016 for an hour rate of approximately \$24/hour for year 2013.

Table 1 shows the estimated annualized burden for the HPID and NPI PRA in hours.

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**TABLE 1. Annual Information Collection Burden**

Regulation Section	OMB Control No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden	Hourly Labor Cost of Reporting (\$)	Total Labor Cost	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
§162.410	0938-New	160,000	160,000	0.33	52,800	24	1,267,200	0	1,267,200
§160.512	0938-New	15,000	15,000	0.50	7,500	24	180,000	0	180,000
Total		175,000	175,000		60,300				760,000

**13. Capital Costs (Maintenance of Capital Costs)**

The start-up costs are reported in Table 1. Maintenance of the identifier will be conducted in the routine conduct of business and is not anticipated to have any additional impact.

**14. Cost to Federal Government**

The Health Plan Identifier System will be built as a module on the Health Insurance Oversight System (HIOS), which is an existing CMS system. In addition, the HPID System will leverage the HIOS help desk to provide support for health plans and other entities as they apply to obtain identifiers. It is estimated to cost approximately \$1.5 million to build the system and operate the help desk. In addition, we estimate that half of a GS-12 equivalent employee's time will be allocated to evaluating and overseeing the program for the first two years. We estimate this will add an approximate \$37,436 per year or \$74,872 in total.

**15. Program Changes**

The burden associated with this collection is increasing because health plans will need to apply to obtain health plan identifiers.

**16. Publication and Tabulation Dates**

There are no publication and tabulation dates.

**17. Expiration Date**

We are not seeking this exception.

