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HEALTH LAW ALERT
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Identifiers for Health Plans and "Other Entities" Adopted

ICD-10 Compliance Postponed for One Year

Today, the Centers for Medicare and Medicaid Services (CMS) formally published a final rule requiring that health plans obtain unique identifiers by November 5, 2014 and that covered entities use those Health Plan Identifiers (HPIDs) to identify health plans in standard transactions[1] beginning on November 7, 2016—more than two years later than the agency had originally proposed in April.[2] In addition, CMS adopted standards for an "other entity" identifier (OEID), which allows (but does not require) third party administrators, benefit managers, health care clearinghouses, and other third parties to obtain a unique identifier for use in standard transactions. Covered entities may (but are not required to) use OEIDs to identify these "other entities" in standard transactions.

The final rule also postponed for one year the date on which covered entities must begin to use ICD-10-CM codes to report conditions and ICD-10-PCS codes to identify procedures in standard transactions. The date on which covered entities are now required to begin using the ICD-10 codes is October 1, 2014.

The final rule is published at 77 *Federal Register* 54663 (click here). Click here for my compilation of the HIPAA Administrative Simplification Rules incorporating the final rule (or see the "Resources" page at tbixbylaw.com) and see the second line under "Compiled Rules."

Health Plan Identifier

The HPID is a ten-digit (all numeric) number. The first digit will indicate the entity is a health plan (as distinct from a health care provider or an "other entity") and the last digit will be a "Luhn check-digit," which "is an algorithm used most often on credit cards . . . to validate that the card number issued is correct." Otherwise, the HPID has no "intelligence"—meaning the remaining digits do not provide information about the health plan. Health plans will be required to obtain an HPID from the CMS Enumeration System, which will collect identifying and administrative information about the health plan and

[1] CMS does not expect the HPID requirements to affect retail pharmacy transactions.

[2] Small health plans—those with annual receipts of $5 million or less—would have an extra year to obtain HPIDs, but would be required to begin using the identifiers by the same date as other covered entities.

disseminate the information through a publically available search function and through downloadable files. Although CMS has not determined exactly what information health plans will have to report to the Enumeration System, the agency expects "that only minimally necessary information will be collected." Although CMS expects that entities may access the Enumeration System "to learn more about the application process" beginning October 1, 2012, it is not clear when the System will be able to begin assigning HPIDs to health plans.

CMS determined that adopting the same compliance date for (1) health plans to obtain HPIDs and (2) covered entities to begin using the identifiers would lead to "significant operational challenges," due to the need for "ample time to perform system changes and [conduct] testing." Accordingly, CMS delayed the date on which covered entities must begin to use the HPID in standard transactions (the compliance date is now November 7, 2016).

Recognizing that "health plans today have many different business structures and arrangements that affect how [they] are identified in standard transactions," CMS will allow related health plans flexibility in determining how many HPIDs related health plans must obtain (see box on right). Although CMS declined to require health plans to obtain an HPID for each specific benefit plan it offered, as some commenters urged it to, CMS left the door open for greater "granularity": "a patient-specific benefit plan identifier is a more specific requirement than we believe would be appropriate to impose **at this early stage**" (emphasis added).

"Controlling Health Plans" and "Subhealth Plans"

The final rule will require "Controlling health plans" to obtain HPIDs, whereas it will allow, but not require, "subhealth plans" to obtain HPIDs.

A "controlling health plan" is a health plan that either (a) controls its own business activities, actions, or policies or (b) is controlled by an entity that is not a health plan. A "subhealth plan" is a health plan whose business activities, actions, or policies are controlled by another health plan.

For example, an insurer that is not owned or controlled by another entity is a "controlling health plan" and must obtain an HPID for itself. If the insurer owns (and controls) an HMO, the HMO is a subhealth plan. Under the final rule, the insurer may decide whether it makes business sense to obtain a separate HPID for its HMO or to simply require the HMO to use the insurer's own HPID.

Transactions Involving Multiple Health Plans

CMS claims that the HPID requirements do "do not require a change to health plans' business models." Rather, CMS asserts that the final rule simply will require covered entities to substitute the HPID for whatever number they currently use to identify a particular health plan in standard transactions. For example, when one health plan adjudicates its enrollees' claims that were submitted by providers that have a contract with a different health plan, CMS explains that "if the health plan that adjudicates the claim needs to be identified in a standard transaction, then the HPID of that health plan should be used. If the health plan

that that holds the actual contract with the provider needs to be identified in a standard transaction, then the HPID of that health plan should be used." Given the number of data elements in standard transactions, the "operating rule" requirements that will be imposed on covered entities, and the variety of health plans' business models, however, CMS's view of the situation may be overly simplistic.

Self-Funded Health Plans

The final rule will require self-funded plans to obtain an HPID,[3] notwithstanding that CMS acknowledges that "very few self-[funded] group health plans conduct standard transactions themselves" and therefore generally do not need to be identified in standard transactions. Indeed, CMS stresses "the HPID of a self-[funded] group health plan will **only need to be used** by covered entities **if** that self-[funded] group health plan is identified in the standard transactions," which rarely is the case (emphasis in original). In short, many self-funded health plans will be required to obtain HPIDs that will never be used.

"Other Entity" Identifier

CMS acknowledges that a variety of "other entities," such as rental networks, benefit managers, third party administrators, health care clearinghouses, repricers, and other third parties "often perform functions similar to, or on behalf of, health plans" and must therefore be identified in standard transactions "in the same fields and using the same type of identifiers as health plans." Accordingly, the final rule adopts an "other entity identifier"—the OEID—which may be obtained by any entity that "[n]eeds to be identified in a [standard] transaction," provided that the entity (i) is not eligible for an HPID or an NPI and (ii) is not an individual. Thus, auto liability and workers compensation insurers also may obtain OEIDs so they can be identified more easily in standard transactions.

The OEID has the same characteristics as the HPID and the National Provider Identifier (NPI), except that the initial digit will indicate the entity is an "other entity" rather than a health plan or health care provider. Like the HPID, CMS cannot now say when the Enumeration System will be able to assign OEIDs, but it does expect the System to be accessible next month.

The final rule will **not** require "other entities" to obtain an OEID. Moreover, when an "other entity" does obtain an OEID, the rule will **not** require covered entities to use the number to identify the "other entity" in standard transactions. CMS suggests, however, that this might change in the future: "we believe it would be helpful to begin with a voluntary approach that allows for gradual implementation and improvised use [of the OEID] based on industry needs and practices."

[3] As with other types of health plans, self-funded plans that are "subhealth plans" may, but will not be required to obtain HPIDs. Thus, for example, an employer's self-funded Health Reimbursement Arrangement might qualify as a "subhealth plan" where the employer's self-funded major medical plan is the "controlling health plan."

ICD-10 and Medical Loss Ratio

CMS's delay of the ICD-10 implementation date has been expected for several months (*see, e.g.*, my April 10 Health Law Alert addressing issue). The delay is due to (1) the delayed implementation date for the Version 5010 standard transactions, (2) providers' conflicts with other statutory initiatives (i.e., the HITECH Act incentive program for adoption of electronic health records), and (3) "surveys and polls indicat[ing] a lack of [provider] readiness for the ICD-10 transition."

Under Affordable Care Act requirements, health insurers are required to meet minimum medical loss ratio standards or pay enrollees rebates. In calendar years 2012 and 2013 (but not in 2014 or thereafter), the Medical Loss Ratio rules permit insurers to treat certain ICD-10 conversion costs as "activities that improve health care quality." This increases the insurers' medical loss ratios, which makes rebates less likely. CMS does not address whether it will revise the Medical Loss Ratio rule to allow insurers' 2014 ICD-10 conversion costs to receive similar treatment. Health insurers should therefore consider Medical Loss Ratio implications in determining the extent to which they put off ICD-10 conversion costs until 2014.

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