What is the Difference Between a Health Plan and a Payer?
Issue Brief

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I. Introduction

The bulk of the healthcare industry’s concerns related to the Unique Health Plan Identifier (HPID) land in two categories:

1. Definition of Controlling Health Plan (CHP) and what is specifically required for health plan enumeration.
   Note: This issue brief does not address this concern.
2. Required use of the HPID in the ASC X12 transactions

The Workgroup for Electronic Data Interchange (WEDI) has conducted ongoing conversations with the Centers for Medicare & Medicaid (CMS) and through those discussions, identified that there are differences in verbiage usage between the terms “health plan” and “payer”. By and large, the healthcare industry tends to use the terms “health plan” and “payer” synonymously. The HIPAA regulation, however, defines “health plan” differently than the way the industry commonly uses the term. This variation in terminology usage has also created additional interpretation issues.

As a result, WEDI engaged ASC X12 to develop this issue brief to aid the industry in understanding the difference between the terms “health plan” and “payer”.

II. Definitions

Health Plan
The HPID Final Rule relies on the definition of “health plan” under HIPAA in 45 CFR §160.103:

“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)).”

The Code of Federal Regulations further defines what types of plans are included in a “health plan”.

Payer
The term ”payer” as used in the transactions is defined as the intended entity that is responsible for one or more of the following:

- final processing of the claim in order to return the remittance advice.
- final processing of the inquiry (eligibility, services review or claim status) in order to return the response (eligibility, services review or claim status).
- final processing of the (member) enrollment or premium payment.
Note: This definition excludes any business associate used to create or receive a transaction on behalf of a payer, e.g. a clearinghouse processing eligibility inquiries and response on behalf of a payer Information Source.

Examples of the value of a payer ID include, but are not limited to NAIC code, EIN, etc.

III. Usage

The role of payer is distinct from the role of a health plan. Even though an entity can be in both roles, not all payers are health plans and not all health plans are payers.

Usage in transactions relies on the identification of the role the entity being identified is playing. While a health plan can be a payer, in the transactions, the entity is being identified for its role as a payer not as a health plan.

Payer

Current use of the payer identification data elements in the ASC X12 transactions is to identify the entity in the role of a payer. Examples of payer identification include the following:

- A health plan, Self-funded Group A, contracts with Insurer A, also a health plan, as their third-party administrator. Insurer A sends and receives the transactions on behalf of Self-funded Group A with providers and clearinghouses. Insurer A, although a health plan, acts in the role of a payer when conducting business for Self-funded Group A. Therefore, it is appropriate to identify Insurer A with a payer ID in their role as a payer.

- A health plan, Insurer B, is a subsidiary of Parent Company C, who does not meet the definition of a health plan. Parent Company C is conducting the transactions for Insurer B. Therefore, it is appropriate to identify Parent Company C with a payer ID in their role as a payer.

- A health plan, Health Plan C, contains a functional unit within its business structure that is the payer, Payer C. Therefore, it is appropriate to identify Payer C with a payer ID when conducting transactions to identify themselves in the role of a payer.

Health Plan

In instances when a health plan chooses to identify itself as a health plan in a transaction, the HPID of the health plan is the identifier that would be used after the HPID Final Rule compliance date. An example of this is payer, Insurer H, collects premium dollars from members for health plan, Self-funded Chamber of Commerce. Insurer H sends a premium payment transaction to Self-funded Chamber of Commerce, who is identified as a health plan premium receiver using Self-funded Chamber of Commerce’s HPID.
Summary
If a health plan, third-party administrator, administrative services organization, or a different entity currently is identified in standard transactions as a payer, it would continue to do so. If the entity currently is identified as a health plan (and continues to be identified as a health plan after November 7, 2016) in standard transactions, it must use an HPID.

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