HPID: The confused birth, troubled life and untimely death of a federal regulation

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Congress passes a law, and designates a federal agency charged with promulgating regulations and carry out Congress' intent as expressed in the legislative language. The federal agency seeks input from concerned stakeholders through notice and comment rulemaking, issues proposed and final rules with prospective effect on the affected industry. Generally, this process works well, at least in the sense that - eventually - rules are issued with which the regulated industry must comply.

Why might this process not work well, and what recourse is available when that happens? A case in point might be the health plan identifier (HPID) originally required by section 262 of the HIPAA statute passed in 1996: the HPID was intended to aid providers and third-party payers with electronically engaging in a wide variety of HIPAA transactions - for example, patient eligibility determinations, claims billing and remittances of health care payments. By using these different numbers issued by different governmental or private organizations, the hope was that by instituting a national and unique identifier for each "health plan," confusion could be avoided in such transactions.

The course of HPID's lifetime, thus far, is as follows: after the initial passage of HIPAA, Congress in the 2010 Affordable Care Act renewed the requirement for development of the HPID, based on the input of the National Committee on Vital and Health Statistics (NCVHS), which is the statutory advisory committee responsible for providing recommendations on health information policy and standards to the federal Department of Health and Human Services (HHS). A NCVHS subcommittee held public hearings during July of 2010 and, after receiving the NCVHS recommendations, HHS published a proposed rule in April of 2012. A final rule was published in September of 2012. In October of 2012, organizations began to apply for HPIDs (some 11,000 numbers were assigned through October of 2014). As that process proceeded, payers and providers reported that the HPID policy was problematic, costly and burdensome. NCVHS held hearings in February and June of 2014 and sent HHS follow up letters in May and September of that year. Effective October 31, 2014, HHS issued a "statement of enforcement discretion," which delayed enforcement of the HPID rule. In May of 2015, HHS requested additional public input, which was overwhelmingly negative. NCVHS held a hearing in May of 2017 which "confirmed that the HPID did not satisfy a business need, did not provide other value, and its implementation would be costly and disruptive." A proposed rule to rescind the HPID requirement was issued in December of 2018, with public comments solicited through February of 2019.

If, as this writer anticipates, the HPID rule is rescinded, its lifespan will have reached over six years, though only during the first two of those years was it in practical effect. Its gestation, from initial HIPAA provision to final rule effective date, was approximately 16 years. Given the lengthy time period and elaborate public input process prior to its promulgation, how did it prove to be so defective?

The first issue may have been that the initial HIPAA definition of "health plan" was confusing, combining, as it did, both health plans and health insurance issuers. This almost guaranteed that there would be confusion as to whether "health plan" means the corporate payer entities (e.g., commercial insurers, ERISA group health plans, Medicaid programs) and/or the plans and products sponsored or administered by those entities (e.g., health, dental, PPO, HMO and indemnity plans, Medicare Advantage plans, and Medicare supplemental policies). This fundamental definition problem was pointed out in a letter from NCVHS to HHS as early as September of 2010. The resulting confusion was reflected in complaints regarding how to interpret regulatory definitions of "controlling health plan" and "subhealth plan."

Another issue may stem simply from the lengthy period of time it took to promulgate the regulation. HHS originally believed in 2012 that the HPID was presented with multiple and inconsistent numbers to "health plans" issued by a large variety of public and private organizations issuing - company codes issued by the National Association of Insurance Commissioners, IRS employer identification numbers, and proprietary numbers assigned by health care clearinghouses. However, as was pointed out by NCVHS in 2014, the industry in the meantime "has moved to the implementation of a standardized national payer identifier based on the [NAIC] identifier. This identifier is now widely used and integrated into all provider, payer and clearinghouse systems." Continued implementation of the HPID requirement would have required the industry to map or crosswalk existing payer ID numbers to the new HPID, possibly resulting in misrouting of claims.

At the end of this lengthy process, HHS conceded late last year that, "we now better understand the significance of providers being able to identify the payer in a HIPAA transaction…The organization that needs to be identified in transactions is the payer, rather than the health plan." Before it came to this realization, NCVHS recommended to HHS that it "rectify in rulemaking" that HPAA-covered entities not use the HPID and that the current payer ID will not be replaced with HPID. In response, HHS took the step of issuing a "statement of enforcement discretion" that gave it time to review the NCVHS's recommendations and consider any appropriate next steps.

An agency's ability to enforce discretion has been the subject of court review under the federal Administrative Procedure Act. The leading case holds that an agency's decision not to take enforcement action is presumed immune from judicial review. That presumption can be overcome, however, if an agency has "consciously and expressly adopted a general policy that is so extreme as to amount to an abdication of its statutory responsibilities." A study published by the Congressional Research Service stated that there is very little case law defining this exception to the general rule, noting that "the dearth of case law relating to agency non-enforcement may be due to the difficulty of finding a plaintiff who has been sufficiently injured by agency inaction to obtain standing." Here, HHS's use of discretionary non-enforcement has enabled it to seek further public input and NCVHS recommendations, leading to the issuance of the recent rule proposing rescission of the HPID requirement. This pause, prior to issuing notice-and-comment rulemaking proposing a prior rule's rescission, can thus be distinguished both from a failure of a regulatory agency to meet a statutory deadline for issuing a rule, and from an agency's blank refusal to undertake its "statutory responsibilities."

Federal case law suggests that if an agency were to make a non-enforcement decision that imposed new legal obligations on the public, or violated specific statutory language specifying when enforcement action is to take place, it might be successfully challenged as acting beyond the recognized limits of its regulatory discretion. An example of how to avoid such a challenge was presented when the IRS issued a notice in 2013 announcing that it would not enforce the "employer mandate" under the Affordable Care Act during 2014, without issuing a new regulation. Because the ACA did not contain specific language as to exactly how that mandate was to be implemented and the IRS action did not impose any new legal obligations on any parties, issuance of a guidance document announcing its enforcement policy was within the agency's recognized discretionary power. These guardrails around agency discretion may be of some comfort to those concerned about the allegedly unchecked power of "the deep state."

This sad regulatory tale highlights the extraordinary difficulty of interpreting statutory language to effectively carry out legislative intent in a complex and rapidly changing industry such as health care. It is a tale of how imprecise or vague legislative language can open the door to an expansive exercise in implementing agency discretion. It is a tale of how, sometimes, a large number of intelligent, experienced people can consider a matter at length and get it disastrously wrong. It is not a tale that is unique or limited to the health care industry. It's a lesson that sometimes complexity in design should be considered not a feature, but a bug.

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