HCR ALERT!

Monday, September 22, 2014

Health Plan Identifier (HPID) and Certification of Compliance

Beginning this November group health plans subject to the Health Insurance Portability and Accountability Act (HIPAA) will be required to obtain a health plan identifier (HPID). The following *Alert* provides a summary of the guidance and instructions currently available regarding the HPID and plan certification requirements.

Background

The final rule published in 2012, adopted a 10-digit HPID that will be used as the standard data element by health plans when processing electronic HIPAA standard transactions. The intent of the unique HPID is to streamline the routing, review and payment of electronic transactions between carriers, administrators, and health care professionals. HIPAA standard transactions include, but are not limited to, the submission and payment of medical, prescription drug, and dental claims, eligibility and enrollment, and premium payments. Health plans will apply for their HPID through the Centers for Medicare and Medicaid Services (CMS) Enterprise Portal.

In addition, the Department of Health and Human Services (HHS) issued proposed regulations in January 2014 that will require group health plans to provide certification that the plan is in compliance with certain electronic transactions. Both fully-insured and self-insured group health plans will be subject to the new certification process.

NOTE: We are issuing this *Alert* so you're aware of the "large plan" November 5, 2014, application deadline. However, outstanding questions and concerns remain regarding the HPID application process specifically for self-insured health plans. We've noted the primary issues in this document, and we suggest due to these concerns a self-insured plan sponsor may want to wait until mid-October to apply for their HPID in hopes additional CMS guidance is provided that will streamline the application process. We will provide another *Alert* as soon as additional guidance is available.

Health Plan Identifier (HPID)

Who needs to obtain a HPID?

Who must obtain a HPID depends on the level of control the group health plan has over its business activities and policies. The basic rule is:

- the insurer obtains a HPID for an insured plan and the employer has no involvement, and
- the sponsoring employer obtains a HPID for a self-funded group health plan.

The HIPAA definition of group health plan applies to these regulations, which means medical, Rx, dental, vision, health reimbursement account (HRA) and health flexible spending account (FSA) plans are included. In an employer situation where some of their group health plans are insured and some are self-funded, both the insurer and the sponsoring employer must obtain a HPID. Also, for multiemployer and other aggregated group health plan arrangements, the plan sponsor is responsible to obtain a HPID. The third party administrator (TPA) or outside broker/consultant is unable to obtain a HPID on behalf of an employer sponsoring a self-funded plan.

The following table shows the most common scenarios for determining who obtains a HPID.

Group Health Plan Scenario	Who Obtains a HPID
All group health plans are insured	Insurer for each plan obtains HPID
All group health plans are self-funded	Sponsoring employer obtains a HPID
Medical plan is insured and one or more of the Rx, dental and/or vision plans are self-funded	Insurer for each insured plan obtains HPID and sponsoring employer obtains a HPID for self-funded plan(s)
Medical and Rx plan are self-funded and dental and/or vision plans are insured	Sponsoring employer obtains a HPID for the self-funded plan(s) and insurer for each insured plan obtains HPID
Medical/Rx, dental and vision plans are insured and HRA and/or FSA have at least 50 participants	Insurer for each insured plan obtains HPID and sponsoring employer obtains a HPID for HRA and/or FSA that are considered self-funded plan(s)
Medical/Rx, dental and vision plans are insured and HRA and/or FSA have less than 50 participants and is self-administered	Insurer for each insured plan obtains HPID but a HPID is not require for the HRA and/or FSA

NOTE: Greater clarification is needed around the new definitions of Controlling Health Plan (CHP) and Sub-Health Plan (SHP), which are important because a CHP must obtain a HPID and a SHP can use the HPID of the related CHP. Also, if a sponsoring employer has multiple self-funded plans it is not clear whether more than one HPID is required. And, it appears the CMS portal only allows one access code per employer, which may create complexity in the application process.

When must employers sponsoring self-funded health plans obtain a HPID?

The compliance deadline varies based on the cost of the plan, as shown in the chart below.

Health Plan Type	Obtain Health Plan Identifier(s) by	Submit Certification of Compliance by
Large Health Plan – Health plans with annual receipts of $5 million or more	November 5, 2014	December 31, 2015
Small Health Plan – Health plans with annual receipts of $5 million or less	November 5, 2015	December 31, 2016
All health plans generating HIPAA electronic standard transactions	Have to use HPIDs in these transactions by November 7, 2016.	

Receipts equal the total amount paid for health care claims during the prior full plan year, and it appears all administration and similar "non-claim" costs, such as stop loss insurance premium do not apply towards the $5 million threshold.

NOTE: Because the HIPAA definition of group health plans includes dental, vision, and prescription drug plans, it's unclear in some scenarios what plans are included in claims "receipts of $5 million or more". It appears that if all self-funded plans subject to HIPAA are consolidated in a single ERISA plan with one 5500 filing for all plans, the employer should consider the claims in all health-related benefits (e.g. medical, dental, vision, etc.) in determining the $5 million threshold. However, clarification around what's included in "receipts" is needed for employer scenarios such as:

1) **an insured medical plan (insurer obtains HPID) and self-funded dental and/or vision plans with less than $5 million in claims that are consolidated in a single ERISA plan and 5500 filing, or**
2) **self-funded medical, dental and vision plans that are stand alone ERISA plans and some or all of them have less than $5 million claims by plan.**

How to apply for the HPID?

The HPID applications are available through the Health Plan and Other Entity Enumeration System (HPOES) which is located on the Health Insurance Oversight System (HIOS). However, in order to access HIOS new users will first need to access the HIOS through the CMS Enterprise Portal. To assist you manage this registration process the following is a high level outline of the required steps.

CMS Enterprise Portal Registration

New users will first need to registration for the CMS Enterprise Portal and request system access to HIOS.

Step 1 – User Registration. In order to complete the HPID application all new users will need to first register on the CMS Enterprise Portal to obtain a user ID and password.

NOTE: The registration process requires Identity Verification (ID Proofing), so the requested information includes individual registrant's personal identifiable information (PII) such as Social Security number, date of birth, home address and primary phone number.

Step 2 – Obtain HIOS System Access. Once registration is completed and the user logs into the CMS Enterprise portal, the user will need to use the "Request Access Now" link to request access to the HIOS Systems/Applications.

- On the "Request New System Access" page the user will choose from the "System Description" drop down box the title "HIOS – HIOS Application".
- Next from the "Role" drop down box the user will choose "HIOS Issuer".
- If not currently a HIOS User the user will need to click the provided hyperlink near the bottom of the page to request access the HIOS System.
- The user will then complete the HIOS Account application and upon submission will receive a notice that the application is pending and an email will be provided within 24 hours with instructions on how to access the HIOS.

NOTE: The CMS help desk has indicated that it may take longer than 24 hours to receive this email – and we've experienced waits of more than 1 week to gain access.

Health Insurance Oversight System (HIOS)

Once the HIOS access is provided, the user will follow the CMS Portal home screen "Access HIOS" link and will arrive at the HIOS Portal Home Page. The following provides the key steps as the user works through the registration and application process.

***Step 1 – Company Registration*.** On the HIOS Home Page click on the "Register an Organization" function. The user will first determine if their organization already exists in HIOS by using the search function. If the company is not currently registered in the system, the user will need to register their organization. Information collected during the registration process includes company legal name, federal employer identification number, incorporated state, domiciliary address.

NOTE: All registration requests are reviewed prior to approval and will receive a notification email once approved.

***Step 2 – Access HIOS user role management*.** Once the company is approved by HIOS, users will need to determine their user role and identify the company to which they need access. On the HIOS Home Page click on "Role Management". There are three different HPOES user roles: Guest User, Submitter User, and Authorizing Official User.

Step 3 – Access HPOES and select an application type. Upon completion of the user role management, the user will access "HPOES" from the HIOS Home Page and begin their HPID application. Note that there are two different HPID applications types: Controlling Health Plan (CHP), Subhealth Plan (SHP). Employer sponsored self-insured group health plans will be considered a CHP.

***Step 4 – Complete and submit an application*.** Users will complete their application and provide the necessary information. The company's Authorizing Official needs to be identified if one has not already been designated.

***Step 5 – Authorizing official reviews application*.** Once the application has been submitted, the company's Authorizing Official will be notified that an application is pending their approval. The Authorizing Official will need to review each application and will have the option to approve or reject it.

***Step 6 –HPID number assigned*.** Upon approval of the application by the Authorizing Official, the system will generate an HPID. An email notification will be sent to the Submitter User with the HPID. Future guidance is to be provided on what organizations need to be provided with the HPID.

Have questions or want more information?

The access and application processes are explained through several resources available on the **CMS website, including short videos and an HPID User Manual.**

- Contact the HIOS Help Desk at 1-877-343-6507 or send an email.
- Visit the Centers for Medicare & Medicaid Services (CMS) HPID page for regulatory guidance, summaries, videos, and tools designed to help you determine if you need a HPID.
- Health Insurance Oversight System (HIOS) - Health Plan and Other Entity Enumeration System User Manual is available HERE.

Certification of Compliance for Health Plans

In January 2014 HHS issued proposed regulations that will require group health plans to submit documentation to demonstrate compliance with certain electronic transactions. These regulations apply to:

- *Fully- insured group health plans*. Under the regulations, insurance vendors for any fully insured group health plans will be required to certify their compliance. No action is needed by the plan sponsor of a fully-insured plan.
- *Self-insured group health plans.* For a self-insured group health plan, the plan sponsor is responsible for providing the plan's certification that it is in compliance with the regulations. In order to do so, plan sponsors will need to obtain certification from each of their business associates that provides a service to the plan. This would include any third party administrator (TPA) or outside consultant.

Due Date – The certification process will occur in two phases. The proposed regulations apply to the initial plan certification submission which will be required in December 2015 and apply to transactions involving eligibility, claim status, and electronic fund transfer and remittance advice.

A second plan certification will also be required that includes the following transactions: claims and encounter information, enrollment and disenrollment, premium payments, claims attachments, and authorizations and referrals. Although the second plan certification is also due in 2015 no guidance has been issued so it is expected that the requirements will be delayed.

More information will be provided regarding these certifications as it is released by HHS. A fact sheet has been released and is available HERE.

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