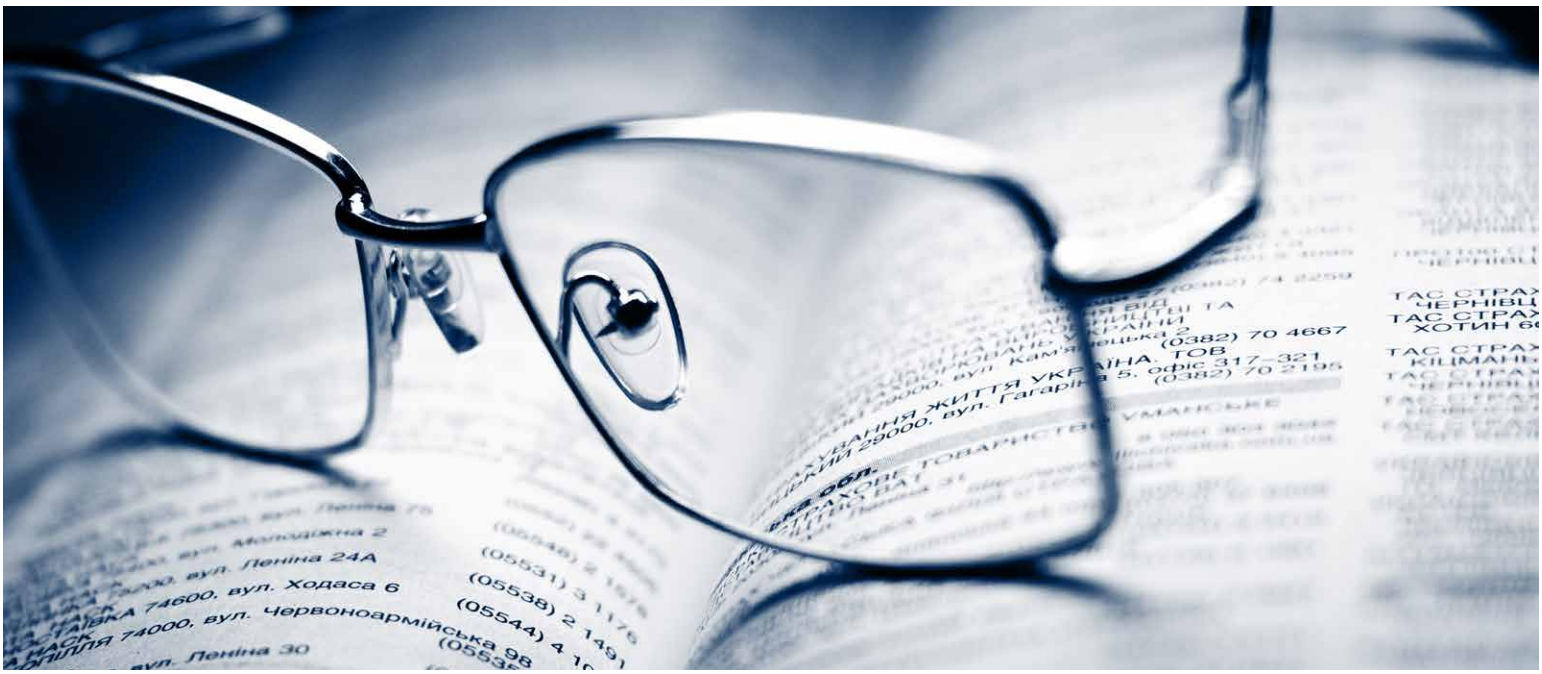
HPID Reference Guide and FAQs

Martin Haitz | (484) 270-2575 | martin.haitz@marcumfs.com



Issued date: 10/09/14

The Affordable Care Act and HIPAA require that health plans obtain a 10-digit health plan identifier ("HPID") by **November 5, 2014** or November 5, 2015, depending on plan size, to be used in certain transactions. The HPID must be used to identify the health plan in all standard transactions beginning November 7, 2016. With some exceptions, health plans must, by December 31, 2015, provide certification to the Department of Health and Human Services ("HHS") of compliance with the standards and operating rules. This reference guide:

- Outlines the requirements around HPIDs;
- Provides action items for employers; and
- Offers FAQs on this topic.

Applicability

The rules apply to "health plans" that perform "covered transactions" electronically between two "covered entities."

"Health plans" include all health-related plans subject to the HIPAA Privacy Rule, including medical plans, dental plans, and vision plans.

However, "health plans" do not include:

- Plans that are self-administered with less than 50 participants;
- Coverage only for accident, or disability income insurance, or any combination thereof;
- Workers' compensation or similar insurance; and
- Coverage for on-site medical clinics.

Health FSAs, HSAs and certain HRAs (if the HRA operates to provide additional plan benefits) are not required to obtain HPIDs.

"Covered transactions" include claims and encounters, payment and remittance advice, claims status request and response, eligibility and benefit inquiry and response, benefit enrollment and disenrollment, referrals and authorizations, and

premium payment. These are activities typically performed by a third-party administrator ("TPA") on behalf of a plan.

A "covered entity" is a health plan, a health care clearinghouse, or a health care provider.

Who is Responsible for Obtaining an HPID?

For self-insured plans, the employer obtains the HPID. TPAs may, but are not required to, obtain the HPID on behalf of the employer, however, many TPAs are reluctant to do so and may charge for such a service. For fully insured plans, the carrier obtains the HPID.

Specifically, a controlling health plan ("CHP") must obtain a number for itself. A CHP is a health plan that controls its own business activities, actions, or policies, or is controlled by an entity that is not a health plan. A health plan is also a CHP if it has one or more subhealth plans ("SHPs") that it controls by directing the SHP's business activities, actions, or policies. SHPs are health plans whose business activities, actions, or policies are directed by a CHP.

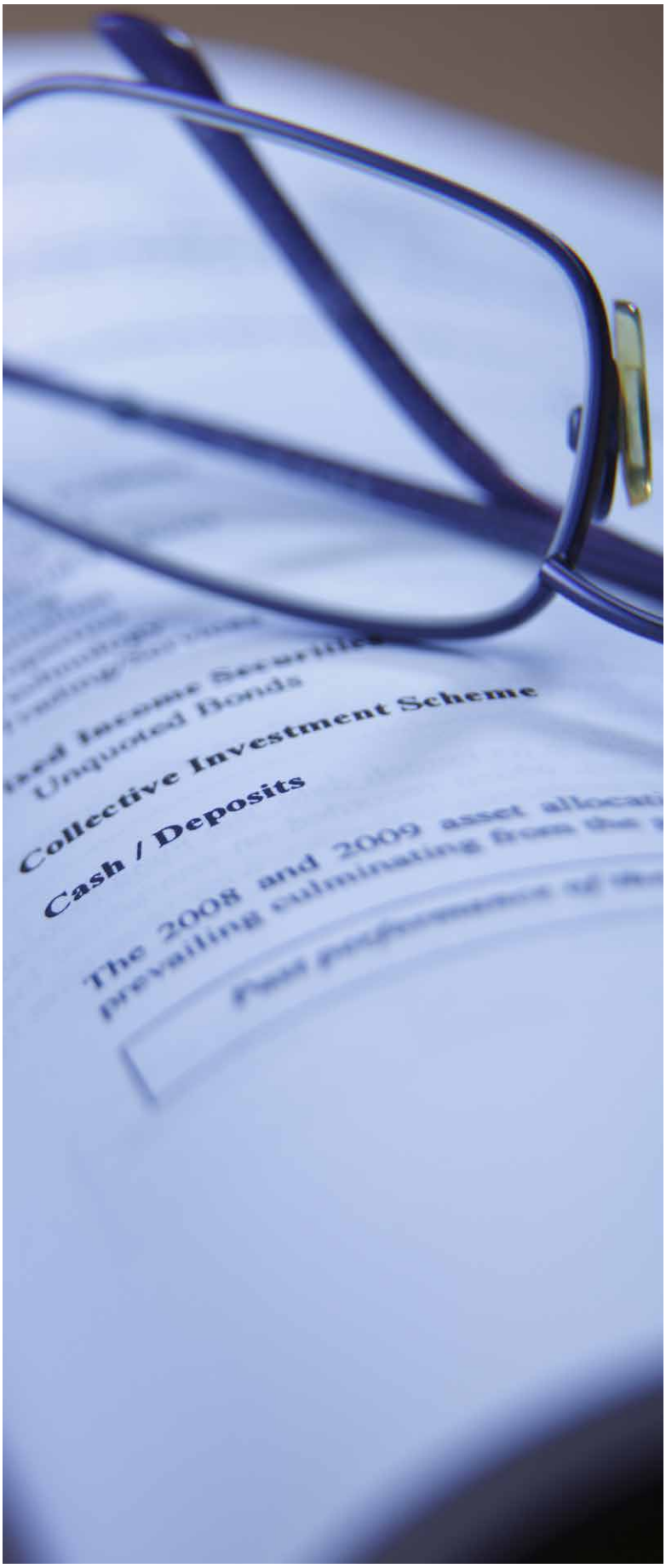
An SHP is eligible, but not required, to get an HPID. To determine whether an SHP should get an HPID, the CHP and/or the SHP should consider whether the SHP needs to be identified in the standard transactions. A CHP may get an HPID for its SHP or may direct an SHP to get an HPID.

Employers with self-funded plans should consult legal counsel if they have questions about whether or not their plans might be CHPs or SHPs.

If an employer offers a wrapped plan, with an insured medical plan and self-insured dental plan, the carrier will obtain the HPID for the medical plan and the employer must obtain the HPID for the dental plan (or delegate that responsibility via contract to the TPA).

Deadlines

	Large Health Plans	Small Health Plans
	>$5m in annual receipts	≤$5m in annual receipts
Obtaining the HPID	November 5, 2014	November 5, 2015
Using the HPID	November 7, 2016	
Certification of Compliance	December 31, 2015	365 days from the date HPID was obtained



To determine "annual claims receipts," a self-insured plan should use the total amount paid for health care claims by the employer/plan sponsor, on behalf of the plan during the plan's last full fiscal year. Those plans that provide health benefits through a mix of purchased insurance and self-insurance should combine proxy measures to determine their total annual receipts. Fully insured health plans should use the amount of total premiums that they paid for health insurance benefits during the plan's last full fiscal year.

How to Obtain the HPID

The Centers for Medicare and Medicaid Services ("CMS") has released a short step-by-step guide to obtaining an HPID number. The quick reference guide summarizes the lengthy steps outlined in the CMS HIOS Portal Manual and CMS HIOS Health Plan and Other Entity Enumeration System Manual ("HPOES").

Briefly, the following outlines the process for obtaining an HPID number for a CHP:

1. Navigate to the CMS Enterprise Portal (https://portal.cms.gov) and register for an EIDM username and password to gain access to the CMS Enterprise Portal.
2. Once inside the CMS Enterprise Portal, apply for access to the HIOS Portal (approval of form may take up to 24 hours).
3. Once registered for HIOS, the user will need to be associated with an actively registered organization within HIOS in order to obtain an HPID.
    - If organization is not yet registered in HIOS, register organization in HIOS before proceeding to HPID application (this process is outlined on pages 16-23 of the CMS HIOS Portal User Manual, http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HIOSHPOESUserManual.pdf).
4. To apply for an HPID number for a CHP within HIOS Portal:
    - Select "Health Plan and Other Entity Enumeration System" button on the left hand menu of HIOS Homepage.
    - User will be directed to the HPOES Homepage for a "Submitter User" (i.e., type of user in HPOES who can complete and submit HPID application on behalf of health plan or other entity).
    - Select "Create Profile and Apply for HPID" button in left hand menu.
    - Provide company information, including NAIC or Payer ID number. If the user does not have an NAIC or Payer ID number, enter "Not Applicable" in the required field (this may be the case for most self-insured plans).
    - Provide authorizing official information.
        - The authorizing official is an individual that has authority to legally bind the entity and holds ultimate responsibility (e.g., CEO, CFO).
    - Certify the accuracy of the application and click "Apply for HPID" button.
        - Application will be sent for approval. It is unclear how long the approval process will take.

Additional processes exist for applying for an SHP HPID and "other entity identification" ("OEID") number. Again, SHPs may, but are not required to, register for HPID numbers.

The CMS quick reference guide can be found here and is a valuable resource for self-insured groups needing to obtain an HPID number: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPIDQuickGuideSeptember2014.pdf.

Using the HPID

All health plans, regardless of size, must begin using the HPID to identify the health plan in a standard transaction beginning November 7, 2016. If the employer/plan uses a business associate (e.g., a TPA) to conduct standard transactions on its behalf, the employer must require its business associate to use an HPID to identify a health plan in all covered transactions. Including this requirement in the service agreement is recommended.

Certification of Compliance

Under a proposed rule, CHPs that obtained an HPID before January 1, 2015 (generally large health plans) must, by December 31, 2015, provide certification to HHS of compliance with the standards and operating rules by showing that the plan conducted its covered transactions in compliance with the applicable regulations. A plan that obtained an HPID after January 1, 2015 (but before December 31, 2016) has 365 days from the date that number was obtained to satisfy the certification and testing requirement. This requirement will generally include documenting the number of covered lives in the CHP and certifying compliance with appropriate credentials. These certification rules are in proposed format and final guidance is expected to further clarify the certification requirement.

Penalty for Noncompliance

Any penalty for noncompliance with respect to self-funded plans is unclear. Proposed regulations only impose a penalty with respect to a "major medical policy" which is defined as an insurance policy that covers accident and sickness and provides outpatient, hospital, medical and surgical expense coverage.

Assuming it does apply, a self-insured health plan may be assessed a penalty if it fails to meet the certification and documentation requirements. HHS will assess a penalty based on each covered life of the CHP (including its SHPs) beginning at $1 per covered life per day, up to certain maximums, until the certification is complete. A plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance will pay a higher penalty subject to an overall limit. The annual penalty fee may not exceed $20 per covered life ($40 per covered life if the plan knowingly has provided inaccurate or incomplete information. The amount of the penalty is subject to increase, based on the percentage of annual national health care expenditures, as determined by HHS.

HHS is required to conduct periodic audits to ensure that health plans (including third parties that it contracts with) are in compliance with any applicable standards and operating rules.

Employer Action

- Identify any (and all) self-insured health plans (including dental, vision, and HRAs that do more than reimburse deductibles and out-of-pocket costs). Health FSAs and HRAs that reimburse only deductibles and out-of-pocket costs do not need an HPID.
- Determine "large health plan" or "small health plan" status to establish deadline requirements.
- Discuss capabilities with TPAs including whether the TPA will register for the HPID number on behalf of the plan and future certification and use requirements.
- Register for HPID number for any CHP.
- Await further guidance on certification and use requirements.

For additional information, visit:

- CMS HIOS Portal Manual: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HIOSHPOESUserManual.pdf
- CMS HIOS Health Plan and Other Entity Enumeration System Manual: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPOESDataelements.pdf

Frequently Asked Questions

When must a health plan obtain an HPID?

A CHP must obtain an HPID by November 5, 2014, unless it is a small health plan (annual receipts of $5 million or less). Small health plans must obtain an HPID by November 5, 2015.

What is a health plan?

A health plan (as defined in 45 CFR 160.103) is an individual plan or group health plan that provides or pays the cost of medical care.

What is a small health plan and what does my organization do if it does not have annual receipts?

A CHP must obtain an HPID by **November 5, 2014**, unless it is a small health plan (annual receipts of $5 million or less). Small health plans must obtain an HPID by **November 5, 2015**.[1]

Self-insured plans, both funded and unfunded, should use the total amount paid for health care claims by the employer, plan sponsor or benefit fund, as applicable to their circumstances, on behalf of the plan during the plan's last full fiscal year. Those plans that provide health benefits through a mix of purchased insurance[2] and self-insurance should combine proxy measures to determine their total annual receipts.

I meet the definition of a health plan[3] but do not conduct any standard transactions. Do I need to get an HPID?

Yes. The HPID final rule adopted the HPID for identification of all entities that meet the definition of a health plan. If the health plan is a CHP, then it is required to get an HPID.

Are self-insured health plans required to get an HPID?

A self-insured health plan must answer two questions to determine whether it must obtain an HPID.

1. Does it meet the definition of health plan under 45 CFR 160.103?
   - A health plan is an individual or group plan that provides or pays the cost of medical care (as defined in 45 CFR 160.103).
2. If it meets the definition of a health plan, is it a CHP?
   - A CHP is a health plan that controls its own business activities, actions, or policies, or is controlled by an entity that is not a health plan. A health plan is also a CHP if it has one or **more** SHPs that it controls by directing the SHP's business activities, actions, or policies.

Are TPAs representing self-insured plans required to obtain HPIDs?

No. All CHPs must acquire an HPID. Many self-insured plans are CHPs and are required to get an HPID whether they conduct standard transactions or not. Since many of them contract with TPAs or other vendors to administer their health plan operations, they may not be aware of this requirement or understand it. A TPA, acting on behalf of a health plan, is not a health plan and is not required to enumerate or identify itself as a health plan in standard transactions. However, a health plan may authorize an entity like a TPA to obtain an HPID on its behalf, but the HPID still belongs to the health plan, not the TPA.

How do I obtain an HPID?

In order to obtain an HPID, a health plan should:

1. Create an account in the CMS Enterprise Portal to obtain a user ID and password.
2. Select the link to register in the Health Insurance Oversight System (HIOS).
3. After registering in HIOS, select the link for the Health Plan and Other Entity Enumeration System (HPOES), and follow the prompts.

There is a User Manual and a Systems Quick Guide to help you navigate to HPOES.

Can a health plan authorize a person to get an HPID for the health plan?

Yes. An authorized person is permitted to enroll the health plan in HPOES.

One component of the sign-up process for an HPID requires an NAIC number or Payer ID. [4] How can a plan (like a self-insured plan) that does not have an NAIC number or Payer ID obtain an HPID?

Plans that do not have an NAIC number of Payer ID should enter "Not Applicable" in that required field.

Are fully-insured plans exempt from the HPID requirement?

No, all CHPs must acquire an HPID.

Who is responsible for obtaining HPIDs for fully-insured health plans?

The health insurance issuer (carrier) is the entity that controls the fully-insured CHP. Since all CHPs are required to obtain HPIDs, the carrier must obtain the HPID for the fully-insured plan. The individual employer plans are SHPs to the fully-insured CHPs. Per regulation, SHPs may obtain HPIDs, but are not required to.

Are Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), Health Savings Account (HSAs), or wrap plans required to get HPIDs?

FSAs and HSAs do not require an HPID. [5]

HRAs may require an HPID if they meet the definition of health plan. No HPID is required if the HRA operates to provide additional plan benefits. For example, HRAs that provide coverage for deductibles only or out-of-pocket costs are not required to obtain an HPID.

Wrap plans and cafeteria plans can be composed of combinations of health plan arrangements. The rules governing these types of plans are the same as for the individual plan types.

For example, a wrap plan that includes fully-insured medical, self-insured dental and an HRA that covers deductibles only requires HPIDs as follows:

- Self-insured dental plan – obtained by the employer.
- Fully-insured medical plan – obtained by the carrier.
- No HPID required for the HRA.

For a list of the FAQs, please visit:
https://questions.cms.gov/faq.php?isDept=0&search=HPID&searchType=keyword&submitSearch=1&id=5005

[1] A small Health Plan is a health plan with annual receipts of not more than $5 million. Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the Small Business Administration at 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts. Health plans that do not report receipts to the Internal Revenue Service (IRS), for example, group health plans regulated by ERISA that are exempt from filing income tax returns, should use proxy measures to determine their annual receipts.

[2] Fully insured health plans should use the amount of total premiums that they paid for health insurance benefits during the plan's last full fiscal year.

[3] As defined in 45 CFR 160.103

[4] Health Plan and Other Entity Enumeration System (HPOES). For more information on HPOES, see the HPID User Manual.

[5] These are individual accounts directed by the consumer to pay health care costs.