Health Plan Identifier ("HPID") Requirements

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Agenda

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- **Certification of Compliance with Standard Transactions Rules**
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Introduction

- Under the original HIPAA administrative simplification statute, which included privacy and security requirements, covered entities were required to conduct certain transactions electronically using standards and code sets designated by the HHS.

- The Affordable Care Act (ACA) added new requirements to these Transaction Rules, including more detailed operating rules and a new electronic transaction requirement for electronic funds transfer (EFT).

- The ACA also required HHS to issue rules for a national Health Plan Identifier number and a new requirement for health plans to certify compliance with all of these Transaction Rules.

Introduction

- For the most part, health plans typically look to their business associates to handle these “standard transactions” responsibilities for them.
- In fact, many TPA agreements and business associate agreements expressly require the business associate to conduct any applicable transactions as standard transactions.
- Alternatively, if a health plan does conduct transactions of its own, it usually hires a clearinghouse to convert the required information into “standard” format.

Introduction

- Some of these new rules, however, place responsibilities directly on the health plan, even if it normally looks to a third party to conduct its standard transactions.

- For example, the health plan must register for its own Health Plan Identifier number to be used in standard transactions.

- And most recently, under proposed rules issued by HHS in January, the health plan must obtain a certification that its standard transactions are being conducted under the required Transaction Rules - even for transactions conducted by its business associates.

Introduction

- Under the proposed rules, by December 31, 2015, health plans will be required to obtain the certification from an outside organization and then file an attestation with HHS that it has obtained the necessary certification.

- Plans may be penalized $1 per covered life per day (up to a maximum cap) for failure to file the required certification.

HIPAA Standard Transaction Rules

- On August 17, 2000, HHS published final regulations adopting the original HIPAA standard transactions, which, after a delay, were effective for most plans as of October 16, 2003.

- The Transaction Rules require that if a health plan covered entity, as defined under the HIPAA privacy rules, conducts certain “standard transactions” with another covered entity using electronic media, the two covered entities must use standards and code sets designated by HHS.

HIPAA Standard Transaction Rules

- These standards and code sets establish which data must be provided and fields that must be used when transmitting electronic information.

- In addition, the Transaction Rules provide that if any entity requests a health plan covered entity to conduct one of the listed transactions as a standard transaction, the health plan must do so and may not delay or reject the transaction because it is standard transaction.

HIPAA Standard Transaction Rules

- **What is a health plan for these purposes?**
  - Group health plans
  - Dental and Vision Plans
  - Health FSAs
  - Health Reimbursement Arrangements (HRAs)
  - HSAs subject to ERISA
  - Individual Policies
  - Some Employee Assistance Plans (EAPs)
  - Retiree Health Plans
- **Which plans are excluded?**
  - Health Plans With Fewer Than 50 Participants That Are Administered by the Sponsoring Employer Are Excluded.

HIPAA Standard Transaction Rules

- The list of transactions to which these rules apply are:
  - Claims & Encounter Information – Request from provider to plan to obtain payment or information.
  - Eligibility – Transmission from provider to plan, or plan to plan – and their responses – related to eligibility, coverage, or benefits under the plan.
  - Authorization & Referrals – Request for authorization for health care or to refer to another provider – and response.
  - Claim Status – Inquiry about status.
  - Enrollment & Disenrollment – Transfer of subscriber information to plan to establish or terminate coverage.

HIPAA Standard Transaction Rules

- The list of transactions to which these rules apply are:
  - Payment – Payment or information about fund transfer from plan to provider's financial institution; or EOB or remittance advice from plan to provider.
  - Premium Payments – Information about payment, fund transfer, remittance, or payment processing from entity arranging provision of care.
  - Coordination of Benefits – Transfer of claims or payment information to plan for purpose of determining relative payment responsibility.

New ACA Requirement: New EFT / Remittance Advice Transaction

- The ACA mandated that HHS adopt a new transaction to add to the list above for electronic funds transfers (EFTs).

- HHS issued a final rule adopting the EFT transaction on January 10, 2012.

New ACA Requirement: New EFT/ Remittance Advice Transaction

- The new EFT / Remittance Advice transaction replaces the Payment transaction in the previous slides and is defined as:
  - Electronic Funds Transactions – Transmission of any of the following from a health plan to a health care provider: payment, information about the transfer of funds, and payment-processing information.
  - Remittance Advice – Transmission of any of the following from a health plan to a health care provider: an explanation of benefits or a remittance advice.
- Covered entities were required to comply with the new EFT/ Remittance Advice transaction by January 1, 2014.

New ACA Requirement: Health Plan Identifier (HPID)

- The original HIPAA administrative simplification statute, enacted in 1996, required HHS to adopt an identifier system for employers, health care providers, health plans, and individuals.

- The intent was to have the same identifiers on a national basis so that all electronic transmissions of health information would be uniform.

New ACA Requirement: Health Plan Identifier (HPID)

- HHS has adopted rules for the employer and health care provider identifier programs, but had not adopted the health plan identifier or individual identifier.

- The ACA again mandated that HHS issue rules adopting the health plan identifier.

New ACA Requirement: Health Plan Identifier (HPID)

- The HPID rules introduce two new terms for defining health plans, which also are used in the new certification rules.
  - Controlling Health Plan (CHP) means a health plan that controls its own business activities, actions, or policies.
  - Subhealth Plan (SHP) means a health plan whose business activities, actions, or policies are directed by a Controlling Health Plan.

New ACA Requirement: Health Plan Identifier (HPID)

- **Who Must Obtain an HPID?**
  - CMS has issued FAQ guidance and a quick reference guide explaining the requirement—and the process—for health plans to obtain health plan identifiers (HPIDs).
  - Fully Insured Health Plans. Based on their control over fully insured health plans, insurers are treated as offering CHPs, and the discrete employer plans are SHPs.
  - Thus, the insurer is required to obtain an HPID for fully insured plans, and employers may, but are not required to, obtain HPIDs for their SHPs.

New ACA Requirement: Health Plan Identifier (HPID)

- **Who Must Obtain an HPID?**
  - Self-Insured Health Plans.
    - A self-insured health plan must obtain an HPID if it:
      - meets the definition of health plan because it provides or pays the cost of medical care; and
      - is a CHP .
    - The FAQs note that a self-insured health plan that is a CHP must obtain an HPID even if it does not conduct standard transactions (e.g., if it uses a TPA to conduct standard transactions on its behalf).
    - A self-insured health plan may authorize a TPA or other person to obtain an HPID on the health plan's behalf, but the HPID still belongs to the health plan
    - Most self-insured plans providing medical care are controlled by the plan sponsor and will fit within the literal definition of a CHP; employers with multiple self-insured plans may want to consider whether one could serve as a CHP for the others.

New ACA Requirement: Health Plan Identifier (HPID)

- **Who Must Obtain an HPID?**
  - Health FSAs, HSAs, and HRAs.
    - As “individual accounts directed by the consumer,” health FSAs and HSAs are not required to obtain HPIDs .
    - HRAs are not required to obtain HPIDs if they are limited to reimbursing deductibles and out-of-pocket costs.
    - The scope of the HRA exemption is less clear— It is assumed that the reference to out-of-pocket costs includes cost-sharing amounts (such as deductibles, co-insurance, and co-pays) for covered services under a health plan.
    - An HRA that reimburses noncovered services (such as acupuncture or Lasik) apparently would not qualify for this exemption.

New ACA Requirement: Health Plan Identifier (HPID)

- **Who Must Obtain an HPID?**
  - Small Health Plans.
    - The FAQs include a reminder that CHPs must obtain HPIDs by November 5, 2014, but small CHPs (those reporting annual receipts of $5 million or less to the IRS) have an additional year to comply.
    - Since most ERISA health plans do not report “annual receipts” to the IRS, the FAQs provide alternative measures:
    - Fully insured health plans should use the total premiums paid during the plan’s last full fiscal year; and 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, on behalf of the plan during the plan’s last full fiscal year.
    - Plans providing benefits through a mix of purchased insurance and self-insurance should combine these measures to determine their total annual receipts.

New ACA Requirement: Health Plan Identifier (HPID)

- **Who Must Obtain an HPID?**
  - For example, if an employer has one self-funded medical plan for active employees, a separate self-funded plan for early retirees, and a separate self-funded dental plan, each plan would have to obtain a separate HPID, unless one plan is designated as the CHP and it applies for one HPID on behalf of itself and the other self-funded plans.
  - Plan sponsors must go on the CMS portal themselves and obtain an HPID.
  - Third-party administrators (TPAs) cannot obtain an HPID for self-funded health plans.

New ACA Requirement: Health Plan Identifier (HPID)

- In addition to HPIDs , the final regulations create an other entity identifier (OEID) for non-health plan entities such as TPAs, repricers, and health care clearinghouses, that may need to be identified in standard transactions as the actual recipient of eligibility inquiries or claims on behalf of a health plan.

- An entity is eligible to obtain an OEID if the entity (1) needs to be identified in transaction for which a standard has been adopted by HHS; (2) is not eligible to obtain an HPID or NPI; and (3) is not an individual.

New ACA Requirement: Health Plan Identifier (HPID)

- Large health plans must obtain an HPID by November 5, 2014.
- Small health plans with $5 million or less in annual receipts have an additional year to obtain an HPID —i.e., their deadline is November 5, 2015.
- All health plans (regardless of size) must use the HPID in standard transactions beginning November 7, 2016.
- The regulations refer to this last date as the “full implementation date.”

New ACA Requirement: Health Plan Identifier (HPID)

- Where an employer has a "wrap" welfare plan that includes more than one health benefit option, these rules appear to allow the wrap plan to apply for one HPID on behalf of all of the Subhealth Plans or to allow each health plan option (i.e., each Subhealth Plan) to obtain its own HPID.

- This structure is similar to the plan number required on the Form 5500.

- Plans may file separate 5500s with separate plan numbers for each health benefit option, or may combine into one 5500 with one plan number.

New ACA Requirement: Health Plan Identifier (HPID)

- Once a health plan has an HPID, any covered entity that identifies the health plan in a standard transaction must use the appropriate HPID number, rather than another identifier.

- In addition, covered entities must require business associates to use the appropriate HPID number when they conduct standard transactions on behalf of a covered entity.

New ACA Requirement: Health Plan Identifier (HPID)

- HHS has established a website where health plans can register and obtain their HPID.
- There are a series of screens the plan must walk through to provide information about the plan sponsor and plan.
- See http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

New ACA Requirement: Health Plan Identifier (HPID)

- A national enumeration system assigns unique HPIDs to eligible health plans and OEIDs to eligible other entities, respectively, through an online application process.
- Access to the enumeration system to obtain HIPDs and OEIDs was made available on March 29, 2014.
- A new user of the application portal must first register by providing required identifying information and creating a user ID and password.
- After registering and logging in, the user must accept the terms and conditions of use of the website, then request application access.
- Further steps are required to gain access to the Health Insurance Oversight System and the HPID and OEID applications.

New ACA Requirement: Health Plan Identifier (HPID)

- The enumeration system collects and maintains certain identifying and administrative information about CHPs, SHPs, and other entities.
- The enumeration system also disseminates information through a publicly available searchable database or through downloadable files.
- Both the HPID and OEID are 10-digit numbers.
- The first digit distinguishes between HPIDs and OEIDs.
- The last digit is a check-digit to identify erroneous or invalid IDs.

New ACA Requirement: Certification of Compliance with Standard Transactions Rules

- The ACA mandates that health plans must file two one-time certifications with HHS attesting that the plan is in compliance with the applicable standard transaction requirements.

- The ACA imposes a penalty on noncompliant plans of $1 per covered life per day until certification is complete with a maximum penalty of $20 per covered life.

- The ACA also imposes a penalty of up to $40 per covered life if the plan knowingly provides inaccurate or incomplete information.

New ACA Requirement: Certification of Compliance with Standard Transactions Rules

- The ACA breaks down the certification into two parts:
  - First Certification - The ACA required the First Certification by December 31, 2013, but new proposed rules issued in January 2014 delay the requirement until December 31, 2015.
  - This certification requires health plans to file an attestation with HHS to demonstrate compliance with the following standard transactions:
    - Eligibility,
    - Claim status, and
    - EFT & Remittance Advice.

New ACA Requirement: Certification of Compliance with Standard Transactions Rules

- The ACA breaks down the certification into two parts:
  - Second Certification – Under the ACA, the Second Certification also is due 12/31/15, but no regulations have been issued yet, so this certification may be delayed.
  - This certification requires health plans to file an attestation with HHS to demonstrate compliance with the following standard transactions:
    - Claims & Encounter Information,
    - Enrollment and Disenrollment,
    - Premium Payments,
    - Claims Attachments, and
    - Authorization & Referrals.

First Certification Requirement

- The First Certification of Compliance would be required for controlling health plans (CHPs), which would report on their own behalf as well as on behalf of their subhealth plans (SHPs).

- CHPs would have to provide a single submission that includes—

  – their number of "covered lives," as defined in the regulations, as of the date of submission of the certification; and

  – documentation demonstrating that the CHP has obtained either of two permissible certifications of compliance—the HIPAA Credential or the CAQH CORE Phase III CORE Seal.

First Certification Requirement

- The submission requirements are a “snap shot” of a CHP’s compliance with the standards and operating rules.

- HHS stated that it does not intend for the information or documentation to be updated or resubmitted on a regular basis—suggesting that this will be a one-time filing requirement.

First Certification Requirement

- Two different methods (both administered by CAQH CORE, the same independent organization that developed the operating rules) to document the First Certification of Compliance—the HIPAA Credential and the Phase III CORE Seal.

- HHS believes either option is a reasonable approach and there may be “any number of reasons” why a CHP may elect one alternative over the other.

First Certification Requirement

- **HIPAA Credential**
  - CAQH CORE is still in the process of developing the HIPAA Credential, which is expected to be finalized before final regulations are issued.
  - The key characteristics of the HIPAA Credential are—
    - Attestation that the CHP has successfully tested the operating rules for each of the First Certification Transactions with at least 3 (and up to 25) trading partners accounting for at least 30% of the total number of transactions conducted with trading partners;
    - Flexibility of external testing—unlike the Phase III CORE Seal, a specific approach to external testing is not required;
    - Provision of contact information, including, but not limited to, name, phone number, and email address, for each of the listed trading partners; and
    - Certification, evidenced by the signature of a “senior-level executive,” that the plan complies with HIPAA's security, privacy, and transaction standards.

First Certification Requirement

- **Phase III CORE Seal**
  - The following four-step process for obtaining a CORE Seal:
    - conducting a gap analysis by evaluating, planning, and completing necessary system upgrades;
    - signing and submitting a pledge to become CORE-certified;
    - conducting testing through a CORE-authorized testing vendor; and
    - applying for a CORE Seal by submitting the proper documentation and fee.

First Certification Requirement

- **Phase III CORE Seal**
  - Unlike the HIPAA Credential, the Phase III CORE Seal specifies the testing process, requiring testing through a CORE-authorized testing vendor using CORE Certification Master Test Suites.
  - Test Scripts, which include a description of the requirements for each operating rule and specific documentation or information necessary to demonstrate compliance with each of the requirements, are the primary tools for each Test Suite.
  - As with the HIPAA Credential, the plan must submit the CAQH CORE HIPAA Attestation Form, signed by a senior-level executive, indicating, to the best of the applicant's knowledge, that the entity is HIPAA-compliant for security, privacy, and the transaction standards.

First Certification Requirement

- **Covered lives**
  - HHS states in the preamble to the proposed regulations that it needs to know the number of covered lives of a CHP (including the number of covered lives of its SHPs) in case it needs to assess penalties for failure to complete the certification.
  - The proposed regulations define “covered lives” to mean all individuals covered by or enrolled in “major medical policies” of a CHP (which would include SHPs), including the subscriber and any dependents covered by the plan.
  - Individuals who are eligible but not enrolled would not be counted.
  - The proposed regulations define “major medical policy” to mean “an insurance policy that covers accident and sickness and provides outpatient, hospital, medical, and surgical expense coverage.”

Action Items

- Employers who conduct standard transactions as part of their plan's administration functions must comply with the EDI Standards.

- Health Plans must monitor new transaction standards and operating rules to ensure continued compliance.

Action Items

- Employers must verify identified all business associates involved with standard transactions and review all business associate contracts for EDI requirements so they can be incompliance.
- Health plans will be out of compliance with these rules if its business associates do not comply with these standards when conducting covered transactions.
- Health plans will rely on business associates to implement the requirements of the rules.
- Employer must document and monitor the obligations of business associates.

Action Items

- Employers must determine if vendors will continue to accept nonstandard transmissions from an employer/plan sponsor and whether any additional charges will be incurred for data that are received and processed in nonstandard format.

- If vendors require the standard format is required and the employer/plan sponsor is not prepared to comply, they must make other arrangements with a health care clearinghouse.

Action Items

- *Employer should obtain an HPID of its Health plans* by November 5, 2014 or 2015.
- Employers will need to identify CHPs and SHPs.
- They will need to decide whether the CHP will request a single HPID for itself and all its SHPs, or whether the SHPs will have their own HPIDs.
- Employers will need to communicate their HPIDs to their business associates in conducting standard transactions.

Action Items

- Employers must review the rules for certifying that the health plan's data and information systems are in compliance with any applicable standards and operating rules.

Action Items

- Business associates should review the rules for the EDI Standards and determine if they have implications for their business operations.
- TPAs should consider whether to obtain OEIDs.
- Employers may require TPAs to use OEIDs.
- TPAs must implement the operating rules as they become effective, which requires advance planning and resource allocation.

Questions???????????

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