



As HPID Deadline Draws Closer: Application Steps for Self-Insured Plans

By November 5, 2014, self-insured health plans with more than \$5 million in annual claims are required to obtain a 10-digit Health Plan Identifier (“HPID”) to use in standard HIPAA electronic transactions. Small self-insured health plans (defined as those with annual claims of \$5 million or less) have a one-year delay and, as such, must obtain an HPID on or before November 5, 2015. Fully-insured plans are also required to obtain an HPID; however, recent guidance makes it clear that the carriers must apply for the HPID on behalf of fully-insured plans.¹

Group health plans should determine the amount of annual claims as follows:

- 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 (i.e., plan) year. The premiums or amounts paid for stop-loss insurance by an employer or sponsor of a self-insured plan should not be included in the amount of receipts/claims.
- 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 (i.e., plan) year.
- Plans that provide benefits through a mix of purchased insurance and self-insurance should combine proxy measures to determine their total annual receipts.

By November 7, 2016, all health plans² must use their HPID in standard electronic transactions. The goal is that the HPID will replace health plan identifiers that currently vary in length and format. This will result in a standardized identification system that is intended to efficiently facilitate the routing of electronic transactions. The standard electronic transactions that will require the use of an HPID include:

- Health claims or equivalent encounter information,
- Health claims attachments,
- Enrollment and disenrollment in a health plan,
- Eligibility for a health plan,

¹ Additional information on HPID(s) can be found in our Technical Bulletin at https://ajg.adobeconnect.com/tb_2014_01/ and our FAQ(s) at <https://ajg.adobeconnect.com/a815130238/p9duqrjd1fw/>.

² Under HIPAA, the definition of a health plan is very broad and includes medical, dental, vision, healthcare FSAs, long-term benefits, health reimbursement arrangements, many wellness programs, and most employee assistance programs. For purposes of an HPID, in general, all self-insured plans must obtain an HPID. However, it is necessary to determine how the plan is structured in order to determine if an HPID is necessary.

- Health plan premium payments,
- First report of injury,
- Health claim status,
- Referral certification or authorization, and
- Coordination of benefits.

Determining a Controlling Health Plan

Plan sponsors of self-insured health plans must identify how many HPIDs they are required to obtain. For purposes of the HPID, there are two classifications of health plans: a Controlling Health Plan (CHP); and a Subhealth Plan (SHP). A CHP is required to obtain an HPID, while an SHP is not required to obtain its own HPID. To determine whether a plan qualifies as a CHP, the final rule published by HHS suggests that the plan sponsor answer the following questions:

- Does the health plan itself provide or pay for medical care?
- Does either the health plan or a non-health plan organization control the business activities, actions, or policies of the health plan?

If the answer to both of these questions is “yes,” then the plan qualifies as a CHP and must obtain an HPID.

With respect to an SHP, the guidance provides that a CHP may get an HPID for its SHP or may direct the SHP to get an HPID. When determining whether an SHP should obtain an HPID, the CHP and/or its SHP must consider whether the SHP needs to be identified in any standard electronic transactions. If the SHP needs to be identified in any standard electronic transactions, then it should obtain its own HPID.

Compliance Pointer:

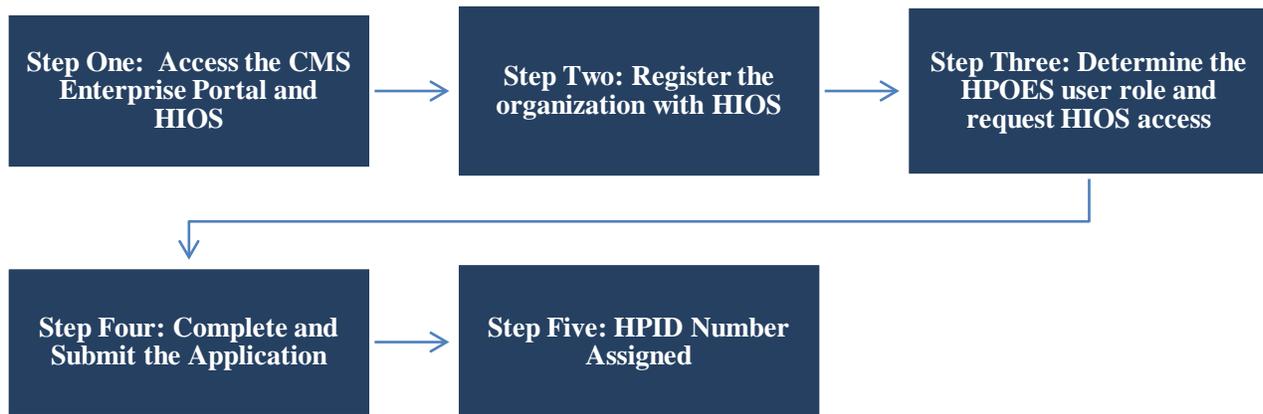
Healthcare FSAs and Health Savings Accounts (“HSAs”) are individual account plans and do not require an HPID. However, a Health Reimbursement Arrangement (“HRA”) may require an HPID if it qualifies as a health plan. However, HRAs that cover only deductibles or out-of-pocket costs do not require HPIDs.

If a self-insured medical plan, a fully-insured dental, and a fully-insured vision plan are wrapped together as a single plan, the plan sponsor (employer) must obtain an HPID for the self-insured plan. The carriers would obtain the HPIDs for the fully-insured dental and vision plans. If an HSA is part of the same wrap plan, a separate HPID for the HSA is not necessary.

According to informal guidance from CMS, the definition of a CHP is very flexible. If, for example, multiple health plans such as a medical plan, a dental plan, and a health reimbursement arrangement are wrapped together and reported on one Form 5500 as one plan, an employer could apply for one HPID covering the “wrapped plan” that includes the medical, dental, and health reimbursement plans. It need not obtain HPIDs for each plan separately.

High Level Overview of Application Process

A CHP or SHP must obtain the HPID via an online application process through CMS’s Health Insurance Oversight System (“HIOS”) available on the CMS Enterprise Portal (<https://portal.cms.gov>). The entire online module is referred to as the Health Plan and Other Entity Enumeration System (“HPOES”). Current HIOS users should have an account to access the Enterprise Portal. New HIOS users must register with the Enterprise Portal to obtain a user ID and password. New users will be required to establish an account and provide identifying information (social security number, date of birth, home address and telephone number). The HPID application process can be broken down into the following steps.



STEP	ACTION ITEM	COMMENTS	COMPLETED
1	Access the CMS Enterprise Portal and HIOS	<ol style="list-style-type: none"> 1) Navigate the CMS Enterprise Portal (https://portal.cms.gov) and click New User Registration. 2) Complete the New User Registration process and receive email confirmation of user registration. 3) Navigate back to the CMS portal and login using the new credentials received in step 2. 4) To establish access to HIOS through the CMS Enterprise portal, click Request Access Now, and then Request New System Access, selecting “HIOS Issuer” (NOTE: CMS documents refer to this option as “HIOS User”) from the dropdown. 5) Navigate the HIOS registration page using the URL provided on the page and complete the HIOS user registration process. 	

STEP	ACTION ITEM	COMMENTS	COMPLETED
		<ol style="list-style-type: none"> 6) Once the HIOS user registration request has been reviewed and approved by the HIOS Helpdesk, an email containing the HIOS authorization code will be provided. 7) Repeat steps 3 and 4 in the CMS Enterprise Portal and enter the authorization code on the Request New System Access page. 8) Log out of the CMS Enterprise Portal and log back in. Users should see a yellow HIOS button on the top left of the dashboard indicating successful access established to the HIOS. 9) Click on the yellow HIOS button, followed by the Access HIOS link to navigate to HIOS Homepage. 	
2	Register the organization with HIOS.	<ol style="list-style-type: none"> 1) Determine if your organization already has access to HIOS by searching the database using your organization's Federal Employer Identification Number (FEIN). If your organization already has access to the HIOS platform, please proceed to Step Two. 2) If the organization does not have access to HIOS, then you must register the organization. To do so, you will need the following information: <ul style="list-style-type: none"> • The organization's legal name, • The organization's FEIN, • The state in which the organization is incorporated, and • The organization's domiciliary address. <p>Once approved, the user will receive an email notification.</p> 	<input type="checkbox"/>
3	Determine the HPOES user role and request HIOS access.	<ol style="list-style-type: none"> 1) Once the organization has been successfully registered, click on Role Management on the HIOS home page. 	<input type="checkbox"/>

STEP	ACTION ITEM	COMMENTS	COMPLETED
		<p>2) Users will need to determine their user role and identify the organization to which they need access. Users will navigate to the Request Role tab, select the HPOES module and either select Submitter User or Authorizing Official User.</p> <p>A Submitter User is a representative of a health plan or other entity that submits an application.</p> <p>An Authorizing Official User is an executive for the organization that has the authority to approve applications, including CEOs and CFOs.</p> <p>If requesting the Submitter or Authorizing Official Role, users will also need to identify the organization to which they wish to be granted access by entering the FEIN and submit the role request. Users can only have one HPOES role at a time.</p> <p>3) After the role is submitted for approval, the user will receive a notifying email once the request is approved.</p>	
4	Complete and submit the application.	<p>A Submitter Users must complete their application with the necessary information.</p> <p>CHP: A CHP that is completing the application will require the following information:</p> <ol style="list-style-type: none"> 1) The organization's information: the organization's name, FEIN, and domiciliary address. 2) The authorizing official's information: first and last name, title, phone number, and e-mail address of the authorizing official. (Please note that the organization's authorizing official needs to be identified, if one has 	<input type="checkbox"/>

STEP	ACTION ITEM	COMMENTS	COMPLETED
		<p>not been designated.)</p> <p>3) The health plan's NAIC number or Payer ID that is used in standard transactions. CMS has provided a self-insured plan can enter NOT APPLICABLE to complete the application.</p> <p>In order to complete the application for a Controlling Health Plan, the Submitter User should:</p> <ol style="list-style-type: none"> 1) Click the HPOES button on the homepage. 2) Select the Create a profile and Apply for HPID button under the Controlling Health Plan function section of the HPOES to initiate a CHP application. 3) Select the organization and provide either the NAIC number, Payer ID, or enter NOT APPLICABLE. 4) Certify the accuracy and submit the application for approval. 5) The user will receive an email confirmation of the submission. <p>SHP: There are two different ways an SHP can apply for an HPID:</p> <ul style="list-style-type: none"> • Select the 'Apply for SHP HPID(s)' button on the HPOES Submitter Homepage; or • Select the 'Apply for SHP HPID(s)' button on the CHP Profile Page. <p>The SHP will need the following information:</p> <ol style="list-style-type: none"> 1) CHP Name/HPID Number. All SHP applications will require the User to identify the organization's 	

STEP	ACTION ITEM	COMMENTS	COMPLETED
		<p>CHP that has already been assigned an HPID.</p> <p>2) The SHP type: company, issuer, product, line of business, and other category.</p> <p>3) The organization information: the organization's name, FEIN and domiciliary address.</p> <p>4) The health plan's NAIC number or Payer ID that is used in standard transactions. CMS has provided a self-insured plan can enter NOT APPLICABLE to complete the application.</p>	
5	HPID number assigned.	Once the application is approved by the Authorizing Official, the system will generate an HPID and will send a notification email with the HPID to the submitter user. The plan sponsor must provide the HPID to its TPA.	<input type="checkbox"/>

Obtaining an HPID is only the start of the process. Plans (those with more than \$5 million in annual claims) must also file a certification with HHS. Plans that obtain an HPID before January 1, 2015 must complete the certification process between January 1, 2015 and December 1, 2015. A plan that obtains an HPID after January 1, 2016, but before December 31, 2016, has 365 days from the date the HPID was obtained to satisfy the certification requirement.

Additional Resources:

- A complete User Manual can be found at: <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HIOSHPOESUserManual0401012014.pdf>.
- A list of data elements needed for the applications is available at: <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPOESDataelements.pdf>.
- A Quick Reference Guide can be found at <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPIDQuickGuideOctober2014v2.pdf>

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.