EXPECT AN EXPERT

Do you need to apply for a Health Plan Identifier?

Despite rumors that Centers for Medicare and Medicaid Services (CMS) would either accommodate or exempt self-funded plan sponsors from applying for a Health Plan Identifier (HPID), no official statement has been made and specified health plans should obtain their HPID by November 5, 2014 under a final rule released by the Department of Health and Human Services (HHS).

What is an HPID?

The HPID is a 10-digit, all numeric code similar to a credit card number to replace proprietary health plan identifiers of varying formats and make health plan information available in a public database to facilitate the routing of transactions.

Which health plans are affected?

Self-insured health, dental and vision plans with more than 50 employee participants are affected. Plan sponsors are required to obtain their own HPIDs for self-insured plans.

For insured health plans, the health insurance issuer, not the employer sponsoring the plan, is generally required to obtain the HPID.

Non-excepted FSAs and stand alone HRAs that cover more than dental and vision expenses are subject to the HPID requirement if 50 or more employee participants are enrolled.

Examples of plans exempt from the requirement

HIPAA excepted health FSAs are exempt from the HPID requirement. The vast majority of Health FSAs offered fall into the category of excepted benefits.

HSAs do not require an HPID.

HRAs that cover deductibles only or out-of-pocket costs incurred by participants enrolled in a fully-insured health plan (integrated HRAs) do not require HPIDs.

All self-insured health plans with less than 50 employee participants enrolled are exempt.

What is the due date for obtaining the HPID?

Health plans with more than $5 million in annual receipts must obtain an HPID by November 5, 2014.

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To determine value of “annual receipts”, plan sponsors may rely on the following CMS information:

Plans not reporting annual receipts to the IRS should use one of the following proxy measures to determine annual receipts:

- The amount of total premiums that they paid for health insurance benefits during the plan’s last full fiscal year.
- 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. It was reported that the premiums or amounts paid for stop-loss insurance by an employer or sponsor of a self-insured plan should not be included.
- For plans providing benefits through a mix of purchased insurance and self-insurance, combine proxy measures to determine total annual receipts.

Delay for Small Health Plans:

Health plans with annual health plan expenses of $5 million or less have an additional year to comply, until Nov. 5, 2015.

By Nov. 7, 2016, all covered entities must use the HPID in standard transactions involving health plans that have an identifier.

What is a controlling health plan (CHP)?

A CHP is a health plan that:

(1) controls its own business activities, actions or policies; or
(2) is controlled by an entity that is not a health plan and, if it has SHPs, exercises sufficient control over the SHPs to direct their business activities, actions or policies.

What is a subhealth plan (SHP)?

A SHP is a health plan whose business activities, actions or policies are directed by a CHP. When deciding whether to obtain an identifier for a SHP, consider whether it needs to be identified in the standard transactions. A CHP may decide to get an HPID for its subhealth plan or an SHP may get an HPID on its own initiative.

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When do I use an HPID?

A covered entity is required to use an HPID when it identifies a health plan in a HIPAA standard transaction. If a covered entity uses one or more business associates to conduct standard transactions on its behalf, the covered entity must require its business associates to use an HPID to identity a health plan in the standard transactions.

Health plans do not need to be identified in transactions made before the HPID requirement.

- A number of additional uses for the HPID are permitted, but not required, such as:
- In internal files, to facilitate processing of health care transactions;
- On an enrollee's health insurance card;
- As a cross-reference in health care fraud and abuse files and other program integrity files;
- In patient medical records to help specify patients' health care benefit packages;
- In electronic health records to identify health plans;
- In federal and state health insurance exchanges to identify health plans; and
- For public health data reporting purposes.

If you are an HBI client, you will receive a step-by-step guide on how to fill out the HPID application within the week from your Consultant or Analyst.

Please note that the information contained in this document is designed to provide authoritative and accurate information in regard to the subject matter covered. However, it is not provided as legal or tax advice and no representation is made as to the sufficiency for your specific company's needs. This document should be reviewed by your legal counsel or tax consultant before use.

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