Legislative Brief

HIPAA - HIPAA Health Plan Identifier

July 21, 2014

Deadline for Health Plans to Obtain HIPAA HPID is Nov. 5, 2014

HIPAA ADMINISTRATIVE SIMPLIFICATION PROVISIONS - HEALTH PLAN IDENTIFIER

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) set standards for electronic transactions that are designed in part to reduce health care costs by encouraging the use of electronic data interchange (EDI), standardizing the electronic processing of health care claims, and improving communication in the health care industry.

HIPAA's EDI Standards are designed to eliminate the need for the hundreds of different proprietary codes and formats historically used in the health care and insurance industries. HIPAA requires HHS to adopt standards for certain transactions to promote the efficient and uniform transmission of health information. One of the standards is a unique health plan identifier for health plans.

HEALTH CARE REFORM AND THE HIPAA HPID

As required under Section 1104(c)(1) of the Affordable Care Act (ACA), HHS issued final regulations in September of 2012 establishing a standard for a national unique health plan identifier (HPID) and provisions to implement the HPID.

PURPOSE OF THE HPID

The primary purpose of the HPID is for use in standard transactions. In standard transactions, the HPID replaces previously used proprietary health plan identifiers with a uniform 10-digit, all numeric code similar to a credit card number. In addition, information about health plans and their HPIDs will be available in a public database to facilitate the routing of transactions.

"EDI Standards" refers to the standardized format, data content, and code set requirements that have been adopted by HHS for certain designated electronic covered transactions.

"covered entities" are defined in the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

"covered transactions" means the types of transactions for which the EDI Standards apply. The EDI standards only apply to the following covered transactions: (a) health claims or equivalent encounter information; (b) health claims attachments; (c) enrollment and disenrollment in a health plan; (d) eligibility for a health plan; (e) health care electronic fund transfers (EFTs) and remittance advice; (f) health plan premium payments; (g) first report of injury; (h) health claim status; and (i) referral certification and authorization.

"standard transactions" refers to covered transactions that are conducted using the EDI Standards.

AFFECTED HEALTH PLANS

For purposes of the HPID, there are two classifications of health plans—controlling health plans (CHPs) and sub-health plans (SHPs).

- 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.
- A SHP is a health plan whose business activities, actions or policies are directed by a CHP.

Health plans include group health plans, health insurance issuers and HMOs. A CHP must obtain a HPID. A SHP is eligible, but not required, to obtain a HPID. To determine whether a SHP should get an HPID, the CHP or the SHP should consider whether the SHP needs to be identified in standard transactions. A CHP may get an HPID for its SHP or may direct a SHP to get an HPID. Below is a summary of the available options.

Entity	Requirement	Options
Controlling health plans (CHPs)	Must get an HPID for itself	• May get HPID for its SHPs • May direct its SHPs to get HPIDs
Sub-health plans (SHPs)	Not required to get an HPID	• May get an HPID at the direction of its CHP • May get an HPID on its own initiative

OTHER ENTITIES

The final rule adopted an optional data element that would serve as an identifier for entities that are not health plans or health care providers but that perform health plan functions and need to be identified in standard transactions. This identifier is called an "other entity identifier" (OEID).

An entity is eligible to get an OEID if the entity:

- Needs to be identified in standard transactions;
- Is not eligible to obtain an HPID;
- Is not eligible to obtain a National Provider Identifier (NPI); and
- Is not an individual.

Examples of entities that are eligible to obtain an OEID include health care clearinghouses, third party administrators (TPAs), and non-HIPAA covered entities, such as auto liability and workers compensation carriers. According to HHS, the OEID will create greater standardization in health care transactions by providing all parties that need to be identified in the transactions with a standard identifier that will be listed in a publicly available searchable database.

USES OF HPID AND OEID

- Required Uses: A covered entity is required to use a HPID when it identifies a health plan in a 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 associate(s) to use a HPID to identify a health plan in standard transactions.
- Permitted Uses: The preamble to the regulations mention a number of additional uses for the HPID that are permitted (but not required), including:
    - 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;
    - inpatient 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

DEADLINES

- **November 5, 2014:** Health plans (other than small health plans) must obtain a HPID by November 5, 2014.
- **November 5, 2015:** Small health plans (*i.e.*, those with annual gross receipts of $5 million or less) have an additional year to comply, and must obtain a HPID by November 5, 2015.
- **From Jan. 1, 2015—Dec. 31, 2015**: Health plans must obtain outside HIPAA Certification of Compliance with Standard Transactions for: (1) eligibility, (2) health claim status, and (3) EFT remittance advice. (Note: This will involve working with the vendors in 2015 to acquire the certification).

- **December 31, 2015**: A health plan with a HPID will need to file an Attestation of Certification with HHS that it processes HIPAA standard transactions in compliance with the law by December 31, 2015.
- **November 7, 2016**: Covered entities must use the HPID in standard transactions beginning November 7, 2016.
- Other entities are not required to get or use OEIDs. The OEID is a voluntary identifier so there is no mandatory compliance date.

Entity Type	Compliance Date for Obtaining HPID	Full Implementation Date for Using HPID in Standard Transactions
Health plans (excluding small health plans)	November 5, 2014	Nov. 7, 2016
Small health plans	November 5, 2015	Nov. 7, 2016
Health care providers	N/A	Nov. 7, 2016
Healthcare clearinghouses	N/A	Nov. 7, 2016

APPLICATION PROCESS

Health plans and other entities submit applications for HPIDs and OEIDs through HHS' Health Plan and Other Entity Enumeration System ("Enumeration System"). The Enumeration System is housed within the Health Insurance Oversight System (HIOS) of the Centers for Medicare & Medicaid Services (CMS). Although the effective date of the final regulations for HPIDs was October 1, 2012, HPIDs and OEIDs were not actually available on that date since the Enumeration System did not become available until March 29, 2014. The Enumeration System assigns unique HPIDs to eligible health plans, and OEIDs to eligible "other" entities, respectively, through an online application process. Users should go to the CMS Enterprise Portal at https://portal.cms.gov/ to access HIOS. The application process involves the following steps:

- Step 1 Register organization in HIOS: To determine if the organization already exists in HIOS, search by the organization's federal employer identification number (EIN). If the organization does not already exist in HIOS, users must register their organization. All registration requests are reviewed prior to approval. The following information is needed to register a new company: company legal name; EIN; incorporated state; and domiciliary address.
- Step 2 Access User Role Management: Users must determine their user role and identify the company they need access to. Users can only have one user role at a time. There are three different user roles:
  - *Guest*: A user that is able to view general information (no company association needed)
  - *Submitter*: A representative of a health plan or other entity that submits an application
  - *Authorizing Official*: An individual who has the authority to legally bind the entity and holds ultimate responsibility, for example, the chief executive officer (CEO), chief compliance officer or chief financial officer (CFO). An Authorizing Official approves applications submitted by the company's submitter users.
- Step 3 Select Application Type: There are two different types of HPID applications, CHP and SHP. If completing a SHP application, users will be required to select a CHP company. There is also an OEID application for other entities.
- Step 4 Complete Application: Users will need to complete their application and provide the necessary information. The company's Authorizing Official needs to be identified if one has not already been designated. SHP applications will display the CHP's Authorizing Official information. All Authorizing Official information provided in the application is reviewed prior to the user being assigned the Authorizing Official role. Users will be able to review their application information prior to submission.
- Step 5 Application Review: Once the application has been submitted, the company's Authorizing Official will be notified that an application is pending approval. The Authorizing Official will need to review each application and will have the option to approve or reject it.
- Step 6 Number Assigned: Once the application is approved by the Authorizing Official, the system will generate an HPID or OEID. An email notification will be sent to the submitter user with the HPID or OEID.

MORE INFORMATION

More detailed information on the HPID and OEID application process, including an HPID User Manual, is available on CMS' health plan identifier webpage.

CERTIFICATION

Health plans generally look to their business associates to handle any applicable transactions as standard transactions on their behalf. For those health plans that conduct transactions on their own, a clearinghouse is usually used to convert the required information into the standard format.

ACA mandates that health plans must file certification attesting that the plan is in compliance with the applicable standard transaction requirements (i.e., HIPAA EDI Standards). There are two certifications. The first certification, regarding three categories of standard transactions (eligibility, claim status and EFT & remittance advice), must be completed and an attestation filed with HHS by December 31, 2015. The second certification is also due December 31, 2015, but this certification may be delayed since no regulations have been issued yet. The second certification will demonstrate compliance with the remaining standard transactions.

Under proposed rules issued by the HHS in January 2014, health plans must obtain certification that their standard transactions are being conducted under the required HIPAA standard transaction rules —even for transactions conducted by their business associates. Health plans are required to obtain the certification from an outside organization , the Counsel for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE), and then file an attestation that it has obtained the necessary certification with HHS.

Health plans may be penalized $1 per covered life per day (up to a maximum penalty of $20 per covered life) for a failure to file the required certification. A penalty of up to $40 per covered life may be imposed if the plan knowingly provides inaccurate or incomplete information.

The HIPAA standard transaction rules require that if a health plan covered entity, conducts certain "standard transactions" with another covered entity using electronic media, the two covered entities must use standards and code sets designated by the Secretary. Further, the HIPAA standard transaction rules provide that if any entity, covered or not, requests that a health plan covered entity conduct a covered transaction as a standard transaction in compliance with the HIPAA standard transaction rules, then the health plan must do so and may not delay or reject the transaction because it is a standard transaction.

Note: Not all transmissions of electronic information as subject to HIPAA's standard transaction rules. The rules are applicable when information is electronically transmitted between two covered entities regarding a covered transaction.

- Example 1: A health care provider files an electronic claim with a health plan. The transaction is a covered transaction between two covered entities and filed electronically, so it does have to be conducted as a standard transaction.
- Example 2: A participant files a claim with a health plan. Although the transaction is a covered transaction, it is not between two covered entities, so it does not have to be conducted as a standard transaction.

ACTION ITEMS

- If not already submitted, a health plan should submit its application for a HPID soon, so a HPID is obtained by November 5, 2014 (small health plans have until November 5, 2015 to obtain a HPID).
- Health plans should determine which plan options are CHPs and SHPs, and whether to request a HPID for each or request one HPID for all of the health plan options that fall under the CHP.
- Once obtained, the HPID should be provided to the health plan's business associates who conduct standard transactions on behalf of the plan.
- A review of the health plan's service agreements and business associate agreements, with third parties who conduct standard transactions on the plan's behalf, should be conducted to ensure such parties are contractually obligated to comply with existing rules (including providing any necessary information, or performing any necessary testing, in order for the health plan to meet HIPAA certification requirements).
- Until final rules are issued, it is unclear what certification will entail, but at the least it will involve testing a minimum number of transactions. A health plan should identify business associates that conduct standard transactions on behalf the plan and make arrangements for the business associates to perform testing so that the plan can be certified. The health plan should allocate sufficient time to coordinate/complete testing and to obtain the required certification, so that the attestation can be performed by December 31, 2015 (small health plans have until December 31, 2016 to file their attestation).

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