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Deadline Approaching to Secure Health Plan Identifier ("HPID")

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Certain group health plans are required to obtain a 10-digit Health Plan Identifier ("HPID") from the Center for Medicare and Medicaid Services ("CMS") by November 5, 2014. Currently various users of the health care system such as health plans, third party administrators ("TPA") and clearinghouses use multiple identifiers which differ in length and format. The HPID is required by HIPAA and creates a standard data element for health plans, including employer sponsored health plans. The HPID is used in electronic transactions involving health plans and is intended to improve accuracy and efficiency in the healthcare experience. Group health plans must use the HPID for HIPAA transactions such as medical and dental claims, claims payment and remittance, referrals and authorizations, benefit enrollment and disenrollment and premium payments.

Who is required to have a HPID?

HIPAA requires medical providers, health insurers, TPAs and other parties involved in HIPAA transactions to obtain HPIDs.

Self-insured group health plans must obtain a HPID if they control their own business activities, actions or policies (e.g., selecting a TPA or health care platform), or are controlled by an entity that is not a health plan such as an employer. These plans are referred to as Controlling Health Plans ("CHPs"). Since most self-insured plans are controlled by their employer sponsors, most will be considered CHPs and the HPID requirement will apply to most self-insured plans. There is a one-year delayed effective date for small self-insured plans which include plans with claims paid (annual receipts) of $5 million or less. The delayed effective date for small self-insured plans is November 5, 2015.

Insured plans are not required to obtain a HPID because the health insurer uses its own unique identifier to conduct electronic transactions on their behalf. In addition, if a self-insured CHP has a sub-health plan, such as a self-insured dental, prescription drug or retiree health care, then the HPID requirement also applies to the sub-health plan. A CHP can obtain one HPID for itself and all sub-health plans or require each sub-health plan to obtain its own HPID. There may be circumstances when there is an administrative advantage to each sub-health plan obtaining their own HPIDs. Employers with self-insured plans should discuss this with their TPAs.

Health reimbursement accounts (“HRAs”) with 50 or more participants are considered to be self-insured under HIPAA because the employer funds the HRA. Accordingly, HRAs (including HRAs associated with fully insured plans) are required to obtain a HPID, unless they only pay for deductibles or out of pocket costs in which case no HPID is required for them. However, an employer with a self-insured plan may choose to obtain a single HPID for the primary plan and the HRA.

Flexible Spending Accounts (“FSAs”) and Health Savings Accounts (“HSAs”) are not required to have HPIDs.

How Does a Health Plan Get a HPID?

Self-funded health plans must obtain the HPID themselves, although their TPA may obtain a HPID for them.However, the HPID is still the group health plan’s HPID.

Self-funded health plans must apply on-line at the CMS website: https://portal.cms.gov. See CMS instructions on the Health Plan Identifier page. The plan will be asked to complete an application which requires several steps. The application requests a Payer ID or NAIC number (for insurance companies and agents) which can be skipped by group health plans for purposes of completing the application. On October 3, 2014, the CMS updated the Health Plan and Other Entity Enumeration System (“HPOES”) application process, which is the step required after you apply for a HPID. Plans that have gone through the process have reported that completing the application is cumbersome. Given this, employers sponsoring group health plans should get started with the application if they have not already done so.

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