DIVERSIFIED BENEFIT SERVICES, INC.
Dedicated to Excellence in Benefit Management Solutions

DBS Notice: 10/23/2014

Health Plan Identifiers (HPIDs) and Health FSAs, HRAs & HSAs

Overview

The Affordable Care Act (ACA) requires certain health plans to obtain a HPID. The good news is that the following account-based plans ***are not*** required to obtain one:

- Health FSAs
- Limited purpose health FSAs
- HSAs
- HRAs that cover deductibles only or out-of-pocket costs such as coinsurance & copayments
- Limited purpose HRAs

The following benefit plans ***are*** required to obtain a HPID:

- HRAs that meet the definition of a health plan
    - HRAs with gross receipts (benefits paid in the prior year) in excess of $5 million would need to apply by 11/5/2014. If the HRA benefits paid in the prior year are less than $5 million the HPID application must be done by 11/5/2015.
- Retiree HRAs
- Fully insured medical plans (the carrier would be responsible for the HPID)
- Self-funded health plan that provides or pays the cost of medical care and is a Controlling Health Plan (CHP)

What is a HPID?

The HPID is defined by CMS as a 10 digit number assigned to health plans which is designed to increase standardization and help covered entities verify information from other covered entities. The number is used to identify health plans in standard transactions.

Background

The original requirement for Health Plan Identifiers (HPIDs) (which is referred to as a 'standard identifier') was required by the original HIPAA law in 1996. The Affordable Care Act (ACA) under Section § 1104(c)(1) required Health & Human Services (HHS) to create rules regarding HPIDs for health plans. The final rule for the HPID implementation was published in the Federal Register on 9/5/2012 and the regulation modified the implementation dates that were originally described in the proposed rules issued on 4/27/2012.

The Centers for Medicare and Medicaid Services (CMS) has indicated the following regarding the identifiers: *The Health Insurance Portability and Accountability Act (HIPAA), the American Recovery and Reinvestment Act (ARRA) that includes the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the Affordable Care Act (ACA) support three goals: improved quality of care, improved individual and population health outcomes, and reduced costs without compromising quality or safety. The key to achieving these goals*

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is the electronic exchange of data, and an underlying requirement of exchanging data is standardization of that data through standard formats, code sets, and stakeholder identifiers.

CMS has also stated that '*… by 2016, we hope to have a database that contains information about all the CHPs and associated SHPs. By knowing the universe of HIPAA covered health plans, we'll be better able to communicate and implement future administrative simplification initiatives.'*

The final HPID rule has two independent and separate areas of requirements. The first is enumeration of an identifier (HPID) and the second is the use of HPID in HIPAA transactions. This DBS notice will focus on the enumeration area which basically states that all controlling health plans must obtain a HPID.

Recent Developments: October 2014 - CMS Released an FAQ – Good News for FSAs, HSAs & HRAs

In October 2014 CMS released FAQ #10718 which included good news for Health FSAs, HSAs and many HRAs. CMS clarified in the FAQ that Health FSAs and HSAs are not required to have HPIDs. Specifically they stated that *'FSAs and HSAs are individual accounts directed by the consumer to pay health care costs. As such, they do not require a HPID'*.

The FAQ stated that certain *'HRAs may require a HPID if they meet the definition of a health plan. HRAs that cover deductibles only or out-of-pocket costs do not require HPIDs as these are more like additional plan benefits than stand-alone plans'*. These types of plans are typically what many DBS clients have implemented over the years.

The FAQ further stated that *'wrap-plans and cafeteria plans can be composed of a combination of health plan arrangements (i.e., self-insured, fully-insured, FSA, HSA, HRA). The rules governing these types of plans are the same as for the individual plan types. For example, a wrap-plan that includes a fully-insured medical plan, self-insured dental plan, and HRA that covers deductibles, would require the employer to obtain a HPID only for the self-insured dental plan. The carrier would be responsible for obtaining the HPID for the fully-insured medical plan. The HRA only covers deductibles; therefore, a HPID is not required'*.

What is a Controlling Health Plan (CHP)?

CHPs are health plans that control their own business activities, actions or policies or are controlled by entities that are not health plans. CHPs must obtain a HPID. HHS has indicated that if a plan answers yes to the following two questions the plan would be a CHP and would be required to apply for a HPID:

1. Does the entity meet HIPAA's definition of a health plan – meaning an individual or group plan that provides or pays the cost of medical care?
2. Does either the entity itself or a non-health plan organization control the business activities, actions or policies of the entity?

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The regulations distinguish between CHPs and Subhealth Plans (SHPs). SHPs are health plans whose business activities, actions or policies are directed or controlled by a CHP. SHPs are not required to obtain a HPID.

What are the Effective Dates and How Does a Plan Determine if a HPID is required?

If a HPID is required the following dates will apply:

- **Large health plans must apply for a HPID by 11/5/2014**
  - Large health plans: annual receipts (meaning paid HRA claims) of $5 million or more
- **Small health plans must apply for a HPID by 11/5/2015**
  - Small health plans: annual receipts (meaning paid HRA claims) of $5 million or less

How to Obtain / Apply for a HPID

Plans should use the CMS web portal located at https://portal.cms.gov to apply for a HPID. You must first establish a new user account and register your plan in the CMS Health Insurance Oversight System (HIOS) and then select the Health Plan and Other Entity System (HPOES). HPOES is a national enumeration system that is designed to assign unique HPIDs through an online application process. The final step in the application process is approval by the plan's 'authorizing official'.

Several data elements will be requested in the application process that include company information (name, EIN, and address), authorizing official information (including name and contact information) and the plan's NAIC number or payer ID for standard transactions. CMS has created several videos, presentations, and explanatory slides to guide plans through the application process.

What Do Employers Need To Do?

Employers with FSAs and HSAs do not need to be concerned about HPID at this time. Employers with integrated HRAs that cover deductibles only or out-of-pocket costs do not require HPIDs either. The CMS FAQ will need to be watched as it could be changed by the agency much easier than a regulation or law could be changed.

Employers with the following plans would need to obtain a HPID:

- HRAs that meet the definition of a health plan
  - HRAs with gross receipts (benefits paid in the prior year) in excess of $5 million would need to apply by 11/5/2014. If the HRA benefits paid in the prior year are less than $5 million the HPID application must be done by 11/5/2015
- Retiree HRAs
- Fully insured medical plans (the carrier would be responsible for the HPID)
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