Health Plan Certification of Compliance with HIPAA Electronic Transaction Standards

The Department of Health and Human Services (“HHS”) issued proposed regulations that will require a controlling health plan (“CHP”) to submit information certifying compliance with certain Health Insurance Portability and Accountability Act (“HIPAA”) electronic transaction operating rules and standards. Previously, certification was required by December 31, 2013. But one important aspect of the January 2, 2014 proposed regulations is the extension of the deadline for certification and submission to HHS from December 31, 2013 to December 31, 2015.

Background

As part of administrative simplification, HIPAA added requirements intended to help reduce health care costs by increasing the use of electronic processing of health care claims and standardizing operating rules governing certain transactions with health plans. Under the rules, HIPAA covered entities that engage in certain specified transactions (called “HIPAA standard transactions”) electronically are required to comply with rules that standardize the format and content of the electronic transactions. “Transactions” are electronic exchanges involving the transfer of information from one covered entity to another for specific purposes. The rules are called the “Electronic Data Interchange” (“EDI”) standards.

Covered entities engaging in HIPAA standard transactions electronically are already required to comply with the EDI standards. If the covered entity uses a business associate to perform HIPAA covered transactions on its behalf, the business associate must follow the EDI standards, and the covered entity must include that requirement in its business associate contracts. The EDI standards apply only to specified covered transactions:

- Health claims or equivalent encounter information;
- Health claims attachments;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health plan premium payments;
- First report of injury;
- Health claim status; and
- Referral certification and authorization.

HIPAA also contains a requirement for the use of a unique identifier for health plans – a health plan identifier (“HPID”). Historically, health plans were identified in HIPAA standard transactions using identifiers from different sources with a variety of formats such as:

- The National Association of Insurance Commissioners’ (“NAIC”) Company code (typically a 5-digit...
Technical Bulletin

- The Department of Labor (“DOL”) and Internal Revenue Service 9-digit Employer Identification Number (“EIN”) along with a 3-digit numeric number (e.g., 501) (used to identify health and welfare plans);
- Proprietary identifiers (used by health care clearinghouses to identify health plans); and
- Other identifiers such as a Tax Identification Number (“TIN”) (used by different organizations for a variety of purposes).

This lack of uniformity created difficulties for health care providers when performing routine activities such as determining patient eligibility. The use of the HPID is intended to increase standardization in HIPAA transactions and allow for a higher level of automation for health care providers - particularly for provider processing of billing and insurance related tasks, eligibility responses from health plans, and remittance advice that describes health care claim payments.

The Patient Protection and Affordable Care Act (“PPACA”) added a requirement that HHS establish rules for a unique identifier by a specific date. HHS issued those regulations in final form on September 5, 2012. (See page 4 for a summary of the HPID requirement.)

**New Certification Requirement**

The proposed regulations do not change the underlying requirements for complying with the EDI standards. The new guidance only introduces a process for certifying compliance with those standards with respect to three specific types of HIPAA standard transactions:

1. Eligibility for a health plan;
2. Health claims status; and
3. Electronic funds transfer (“EFT”) and electronic remittance advice (“ERA”).*

*EFT generally refers to electronic payment, ERA to documentation that accompanies a payment such as an EOB

The statutory deadline for certification by health plans was December 31, 2013. The proposed regulations officially delay the certification requirement for two years until December 31, 2015. However, in the Preamble to the proposed regulations, HHS reminds covered entities that while the certification process has been delayed, the underlying requirement to comply with the EDI standards has not. Compliance for transactions involving eligibility for a health plan and health claims status were required by January 1, 2013; compliance with the EFT and ERA rules was required by January 1, 2014 based on regulations issued on January 10, 2012.

**Obtaining Certification**

A controlling health plan (“CHP”) is responsible for obtaining the certification. A subhealth plan (“SHP”) may provide certification for itself, or the appropriate CHP may certify on behalf of the subhealth plan. The September 5, 2012 final regulations governing the requirement to obtain and use a unique national HPID defined CHPs and SHPs as follows:

“Controlling health plan (CHP) means a health plan that –

1. Controls its own business activities, actions, or policies; or
2. (i) is controlled by an entity that is not a health plan; and (ii) if it has a subhealth plan(s) (as defined in this section), exercises sufficient control over the subhealth plan(s) to direct its/their business activities, actions, or policies.
Subhealth plan (SHP) means a health plan whose business activities, actions, or policies are directed by a controlling health plan.”

Unfortunately, the regulations do not clarify how “plan”, “controlling health plan” and “subhealth plan” specifically apply to employer-sponsored plans. Clarification would be welcome.

The proposed regulations identify two methods that may be used by a CHP to certify compliance with HIPAA’s EDI standards – obtaining either a HIPAA Credential or a Phase III CORE Seal. The process for obtaining each is described briefly below.

**HIPAA Credential** – to obtain the HIPAA Credential, a CHP must submit to the Council for Affordable Quality Healthcare (“CAQH”) Committee on Operating Rules for Information Exchange (“CORE”) both an application and an attestation. In the attestation, the CHP must confirm that it has successfully tested including end-to-end testing of the operating rules for eligibility for a health plan, health care claim status, and health care EFT and ERA transactions with its trading partners. For each of the three types of transactions, the CHP must test with at least three - and in some cases up to 25 - trading partners successfully.

**Phase III CORE Seal** – a CHP must obtain a separate CORE Seal for each of the three types of transactions – eligibility for a health plan, health care claim status, and health care EFT and ERA. In the Preamble, regulators describe a four-step process for obtaining a CORE Seal: (1) conduct a gap analysis by evaluating, planning, and completing necessary system upgrades; (2) sign and submit the CAQH CORE Pledge to make a commitment to become a CORE-certified entity within 180 days; (3) conduct testing through a CORE-authorized testing vendor; and (4) apply for a Phase III CORE Seal by submitting the proper documentation and fee to CAQH CORE.

The CHP is responsible for making the submission to HHS even if the three types of standard transactions are performed by a business associate (“BA”) on behalf of the CHP rather than by the CHP itself. In the Preamble, regulators state that they had considered requiring CHPs to require their BAs to comply directly with the requirements, but have chosen not to pursue that option. As a result, CHPs that use a BA to perform any of these three covered transactions must require their BAs to comply with the requirements to obtain the necessary certification since the CHP will be attesting that its BAs have obtained the necessary certification in its submission to HHS.

**Submitting Documentation to HHS**

Once the CHP has obtained the necessary certification, the CHP must submit documentation of compliance to HHS and report on the number of covered lives under its major medical policy. Covered lives of a CHP is defined as individuals covered by or enrolled in the major medical policies of a CHP (and SHPs) on the date of submission to HHS. A major medical policy is defined as “an insurance policy that covers accident and sickness and provides outpatient hospital, medical and surgical expense coverage.” Individuals covered by other non-major medical policies would not be included in the count of covered lives. Covered lives includes, but is not limited to, individuals, spouses, dependents, employees, subscribers, policyholders, Medicaid recipients, Medicare beneficiaries, Tricare beneficiaries, veterans, and survivors.

CHPs that obtain an HPID before January 1, 2015 (large health plans must obtain an HPID by November 5, 2014; small plans by November 5, 2015), must complete the submission process between January 1, 2015 and December 31, 2015 (small health plans have an additional year). HHS will be ready to accept submissions beginning on January 1, 2015. New CHPs will have one year after the time they obtain an HPID to submit required documentation to HHS.

CHPs that do not comply with the requirement to obtain certification and submit the necessary documen-
tation to HHS will be subject to a penalty of $1 per covered life per day until certification is complete. The penalty is doubled if the CHP knowingly provides inaccurate or incomplete information in certifying compliance. The statute caps the penalties against a CHP on an annual basis at $20 per covered life ($40 if the penalty is doubled for intentionally providing bad information). The penalty applies only to the CHP; no penalty applies to BAs. However, a CHP may want to include an indemnification provision in its business associate agreement.

**Unique Health Plan Identifier (“HPID”)**

As noted above, health plans must obtain unique health plan identifiers. The HPID is a 10-digit, all numeric identifier with a check-digit as the 10th digit. Each controlling health plan must obtain its own HPID directly from HHS’ Health Plan and Other Entity Enumeration System (“HPOES”). A controlling health may obtain an HPID for a subhealth plan from the Enumeration System or require its subhealth plan to obtain an HPID. A subhealth plan may obtain an HPID for itself even if not directed to do so by its controlling health.

Health plans are required to obtain an HPID no later than November 5, 2014 (November 5, 2015 for small health plans, which are defined as plans with annual receipts under $5 million) and use the HPID in standard transactions beginning on November 7, 2016. Health plans are defined under the statute to include health insurance issuers, HMOs, and group health plans. Insurance carriers will be responsible for obtaining HPIDs for insured group health plans. Self-insured group health plans will be required to obtain their own HPIDs. Health plans must also provide their HPID to business associates (“BA”) that conduct HIPAA standard transactions on their behalf and must require those BAs to use their HPIDs in those transactions beginning in 2016. (Note: unlike HIPAA portability requirements, the EDI standards would also apply to certain plans such as stand-alone dental and vision plans. It appears that the requirements would also apply to health care FSAs since virtually all are self–funded. There is an exemption for a self-administered and self-funded health plan that covers fewer than 50 participants. However, an FSA that is a health “plan” and has receipts under $5 million would have until November 5, 2015 to obtain an HPID. In addition, many health care FSAs do not currently conduct transactions electronically. Based on an FAQ that was on the CMS website (but is not listed currently), FSA payments to providers using debit and credit cards are not subject to the EDI standards. Additional guidance on this issue would be welcome.)

The HPID must be used when the health plan is identified in a HIPAA standard transaction. It is not required for other purposes, but may be used for any other purpose that is lawful. The regulations include several examples of permitted uses: in internal files to facilitate the processing of health care transactions, on health insurance ID cards, as a cross-reference in fraud and abuse files, to identify the health plan in an electronic health record, and for public health data reporting.

Non-health plan entities such as third party administrators, repricers, and rental networks may also need to be identified in HIPAA standard transactions. These entities often perform functions on behalf of health plans and may be identified currently in standard transactions in the same fields as health plans. These entities will be permitted, but not required, to obtain a unique Other Entity Identification Number (“OEID”) for use in standard transactions. Entities that are eligible to obtain either an HPID or an NPI (National Provider Identifier) are not eligible to obtain an OEID. The OEID will use the same format as the HPID, but will have a start digit that identifies the entity as another entity. Similar to the HPID, the OEID may be used for other lawful purposes. An organization that obtains an OEID would be expected to disclose it upon request to entities that need to identify the other entity in covered transactions.

HPIDs and OEIDs will be assigned by the Enumeration System through an online application process. A health plan or other entity, when applying online for an HPID or OEID, will be required to provide certain identifying and administrative information for verification and eligibility determinations during the
application process. A help desk or other applicant assistance functionality will be available to assist health plans with and troubleshoot the online application process.

In addition, each CHP must communicate changes (updates, corrections, etc.) to its own data to the Enumeration System within 30 days of the date of the change. While either a CHP or an SHP may obtain the HPID for a SHP, the responsibility for obtaining the HPID and updating the information in the Enumeration System rests with the SHP.

The Enumeration System will also be able to deactivate or reactivate an HPID or OEID based on receipt of sufficient information to justify deactivation or reactivation. For example, an HPID might be deactivated in the event of the fraudulent use of the HPID or it might (or might not) be deactivated following a merger.

**Next Steps**

Self-funded group health plans that are CHPs should begin the process of applying for an HPID, if that process has not already been completed. Although the process for applying was not operational when the regulations were issued in September 2012, the HPOES system became available in March 2013. Information about the HPOES system and application process is available on the Centers for Medicare and Medicaid Services ("CMS") website. The CMS website has a variety of materials including a 12-minute video and PowerPoint slides with an overview of the process, a list of the data elements needed for the application process, and a link to the CMS Portal where a CHP may begin the process by registering for an account:

- Video Overview (12 minutes) [click here]
- Overview Slides¹ [click here]
- Data Elements [click here]
- CMS Portal [click here]

Fortunately, CHPs have additional time to become familiar with the new certification requirement since HHS will not be accepting submissions until January 1, 2015 and completion of the process is not required until December 31, 2015. Small health plans—which have until November 5, 2015 to obtain an HPID and new health plans, have 365 calendar days after the date on which the plan obtains an HPID to comply with the certification requirement. In addition, the new certification and submission requirements are contained in proposed regulations, and comments will be accepted if submitted before March 4. Regulators may make changes before final regulations are issued. (The HPID regulations are in final form.)

Currently, the new certification requirements apply only to the three types of transactions specified in the regulations. However, in the Preamble, the regulators state that they anticipate expanding the rules to encompass other types of transactions in future guidance.

¹. There are a total of 101 slides in the presentation which covers the process for CHPs, SHPs and other entities that may need an identifier. For many it will not be necessary to view all of the slides.

The intent of this Technical Bulletin is to provide general information regarding on employee benefit plan issues. 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.