Q&A from Assurex Global Webinar "Health Plan ID Number"	July 31, 2014
Question	**Answer**
Q: Are the deadlines to certify the same for plans that are not calendar year plan years?	A: YES - the deadline for certification of compliance with HIPAA rules for standard transactions is December 31, 2015 regardless of plan year.
Q: Are their penalties for not obtaining the HPID? Q: What about the certification process?	A: There is no specific penalty set forth for failure to obtain a HPID number; In regards to certification, the ACA imposes a penalty on plans that fail to certify compliance of $1 per covered life per day until certification is complete, with a maximum penalty of $20 per covered life.
Q: As a partial self insured plan thru CIGNA are we required to obtain a Health Plan ID Number? Q: What about a partially self funded plan? Do you still need a HPID number? Q: Can the benefits manager be the authorizer or does it need to be an officer?	A: For "partially" self-funded plans, it will be necessary to work with the carrier to determine whether or not the carrier considers the plan to be fully-insured and is obtaining a HPID number on the plan's behalf. If the carrier considers the plan to be self-funded, it will be necessary for the employer/plan sponsor to obtain the HPID number. A: The guidance does not specify the exact level of employee required for an authorizing official However, it must be someone with the authority to legally bind the entity. In the CMS HPID instructions manual, the Authorizing Official is described as: *"an individual that has the authority to legally bind the entity and holds ultimate responsibility, for example the chief executive officer (CEO), the chief compliance officer, and the chief financial officer (CFO)."*
Q: Do we have to get any kind of certification from our fully insured plans such as dental?	A: The carriers should be taking care of the certification on behalf of any fully-insured plans. Therefore, it is not necessary for the employer to do anything.
Q: Dental and Vision have to be fully insured to be a covered entity? If they are not where do they fall.	A: Not quite. The illustration in the presentation was simply providing some examples of covered entities, business associates, and those not considered to be covered entities. In general, group health plans (not the employer) are considered covered entities regardless of whether they are self-funded or fully-insured.
Q: Does the HPID cover both a self-funded medical and dental plans? Q: Do you only need 1 HPID if you have self-funded health; self-fund dental; FSA - all separate policies and providers? Q: Is there a separate HPID required for each Plan, such as medical or dental, particularly if they have different TPAs?	A: There is limited guidance on how many HPID numbers an employer should acquire. At this point we recommend that if the employer has "wrapped" all of their self-funded benefits into a single ERISA plan, then only 1 HPID number may be necessary. If, on the other hand, for example the employer submits a 5500 with different plan numbers for each self-funded plan, a reasonable interpretation seems to be that each self-funded benefit should have a separate number. Additional guidance from CMS would be helpful in this area.
Q: Our self-funded plan is one plan but includes 7 separate entities each with own EIN can I do one HPID for all? Q: I am curious to know if I have 2 companies the employees share one health plan for both companies, will I need to obtain a HPID number for both companies? Q: If an employer is part of a self funded co-op do they have to get an ID or is it the plan that needs the ID?	A: The HPID is acquired for a plan, not an employer/plan sponsor. So if multiple employers participate in the same plan, the plan would still acquire a single HPID number.

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Q: FSAs and HRAs are considered self-funded under ERISA, do all sponsors of a Health FSA need to get an HPID? Q: What about a fully insured medical plan w/ a self-funded HRA? Does the HRA need a HPID?	A: Only plans that process HIPAA standard transactions are required to use a HPID. Many Health FSAs only do transactions between the FSA and the participant. This kind of transaction is not a HIPAA standard transaction. However, it is possible that a Health FSA may be administered in a manner that involves a HIPAA standard transaction, such as a direct reimbursement to a provider. The employer/plan sponsor should check with the vendor that administers the Health FSA to determine if plan administration includes any HIPAA standard transactions.
Q: So if I send enrollment information to insurance companies for my clients employee will I need an HPID number (I'm an agent not a TPA)?	A: A TPA or Business Associate such as an agent does not acquire a HPID. Only the plan sponsor for a self-funded plan needs a HPID. The plan sponsor will then provide the HPID to the TPA or business associate if it is necessary.
Q: Is the HPID requirement an outgrowth of HIPAA compliance or 6055 and 6056 / ACA reporting?	A: The HPID is required due to HIPAA transaction rules contained in HITECH and the ACA. It is not related to employer 6055/6056 reporting requirements.
Q: I completed the steps for receiving my HPID however I don't know if I actually received it once the application was approved. Where can I verify that a HPID has been assigned?	A: The submitter and authorizing official should have received an email with the HPID number once the process is complete. You can also log into the HIOS system and view assigned HPID numbers.
Q: If you have a CMS portal account from completing medicare/medicaid questionnaires, do you need to set up another CMS account?	A: It shouldn't be necessary to obtain another CMS portal account. Rather, this will allow you to skip this step.
Q: Is there a fee for getting an HPID and if so how much?	A: No - CMS does not charge a fee for acquiring a HPID number. A vendor or business associate may charge a fee to assist an employer in the process of acquiring the number.
Q: Often FSAs & HRAs & HSAs process prescription drugs without claim submission. Is this therefore considered Standard HIPAA Transaction? Q: How about debit cards in an hra/ hsa/ etc	A: Due to the wide range of administrative arrangements, it is impossible for us to definitively state if any particular arrangement involves a HIPAA standard transaction. Employer/Plan Sponsors should discuss this with their vendor to determine if the business associate processes any HIPAA standard transactions on behalf of the plan.
Q: So at the end of the day if the group has more than 5 million in claims they need to go through the process of obtaining an HPID. Then next year they will need to certify.	A: Self-funded large group health plans (> $5 million in claims) need to obtain a HPID number by November 5, 2014. Self-funded small group health plans need to obtain a HPID number by November 5, 2015. All self-funded group health plans will need to work with TPAs/service providers in order to ensure certification is completed by December 31, 2015.
Q: We have our health insurance through a carrier who handles all the claims and payments. If the employee brings in their EOBs we will reimburse the employee part of the high deductible and coinsurance. Are we considered Self-Funded that we would need to get the HPID number?	A: This type of arrangement (typically referred to as a Health Reimbursement Arrangement or 105 plan) is considered a self-funded plan. However, if the only transactions are between the plan and the participant, then there are no HIPAA standard transactions and the plan would have no use for a HPID.

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Q: Why do we (the employer) need a HIPAA policy and practices if we do not handle HIPAA protected transactions?	A: HIPAA Privacy and Security requirements for employer-sponsored health plans are a completely separate set of rules from the HIPAA transaction rules. Virtually all employer-sponsored health plans, self-funded and fully-insured, are considered covered entities and are subject to the HIPAA Privacy and Security rules to some extent.
Q: Does "in receipt" include $ spent on our agent/service from them?	There is limited guidance form CMS on determining exactly what to include in the definition of receipts for a self-funded plan. We do not recommend including broker or consultant fees in the determination of total receipts. A CMS Q&A explains the "proxy measures" that should be used to determine annual receipts by ERISA plans. CMS states, "Self-insured plans,...should use the total amount paid for health care claims by the employer, plan sponsor or benefit fund,...on behalf of the plan during the plan's last full fiscal year (i.e. plan year)." Furthermore, a separate Q&A notes that, "the premiums or amounts paid for stop-loss insurance by an employer or sponsor of a self-insured plan should not be included in the amount of receipts."