



## HPID Requirement Delayed Indefinitely

Provided by JFP Benefit Management Inc.

### Quick Facts

- Controlling health plans were required to obtain an HPID by Nov. 5, 2014.
- Small health plans had an additional year (until Nov. 5, 2015) to comply.
- On Oct. 31, 2014, enforcement of the HPID requirement was delayed until further notice.

On Oct. 31, 2014, the Centers for Medicare & Medicaid Services announced that enforcement of the HPID requirement is delayed until further notice.

The Health Plan Identifier (HPID) is a standard, unique health plan identifier required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). The initial deadline for health plans to obtain an HPID was Nov. 5, 2014.

On Oct. 31, 2014, the Centers for Medicare & Medicaid Services (CMS) announced that **enforcement of the HPID requirement is delayed until further notice**. This delay applies to:

- The requirement that health plans obtain an HPID; and
- The use of the HPID in HIPAA standard transactions.

This enforcement delay means that health plan sponsors who are subject to the HPID requirement and have not yet received their HPIDs can hold off for now.

CMS has not indicated if there will be a new deadline for obtaining the HPID, or when the new deadline will be. Health plan sponsors who have already obtained HPIDs should maintain a record of their identifier.

### HPID Requirement

The HPID is a standard, unique health plan identifier that is primarily intended for use in standard transactions. The HPID is intended to replace proprietary health plan identifiers that vary in lengths and formats.

The HPID requirement applies to group health plans subject to HIPAA's administrative simplification provisions. However, health plans that have fewer than 50 participants and are administered by the employer that maintains the plan are NOT subject to the HPID requirement.

### Controlling Health Plans and Sub-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. **All CHPs must obtain an HPID.**

An SHP is a health plan whose business activities, actions or policies are directed by a CHP. **An SHP is eligible, but not required, to obtain an identifier.** To determine whether an SHP should get an HPID, the CHP or the SHP should consider whether the SHP needs to be identified in the standard transactions. A CHP may get an HPID for its SHP or may direct an SHP to get an HPID.

#### **Initial HPID Deadlines**

The initial deadline for health plans (except small health plans) to obtain their HPIDs was **Nov. 5, 2014.**

Small health plans (those with annual gross receipts of \$5 million or less) were given an additional year to comply, until **Nov. 5, 2015.** By Nov. 7, 2016, all covered entities were to use the HPID in standard transactions involving health plans that have an identifier.

For purposes of determining whether a health plan has annual receipts of \$5 million or less:

- Fully insured group health plans should use the amount of total premiums that they paid for health insurance benefits during the plan's last full fiscal year.
- Self-funded plans should use the total amount paid for health care claims by the employer, plan sponsor or benefit fund, as applicable to their circumstances, on behalf of the plan during the plan's last full fiscal year.
- Plans that provide health benefits through a mix of fully-insured and self-funded arrangements should combine total premiums and health care claims paid to determine their annual receipts.

#### **Indefinite Delay of the HPID Rules**

The CMS Office of e-Health Standards and Services (OESS) is responsible for enforcement of compliance with the HIPAA standard transactions, code sets, unique identifiers and operating rules, including the HPID requirement.

The OESS issued a Statement of Enforcement Discretion, which provides that, effective as of Oct. 31, 2014, there is a delay, until further notice, in enforcement of the regulations pertaining to the process of obtaining an HPID and use of the HPID in HIPAA transactions.

This enforcement delay applies to all HIPAA covered entities, including healthcare providers, health plans and healthcare clearinghouses.

The OESS statement explained that the delay was prompted by a [recommendation](#) of the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS.

On Sept. 23, 2014, the NCVHS recommended that HHS provide in rulemaking that all covered entities (health plans, healthcare providers and clearinghouses, and their business associates) not use the HPID in HIPAA transactions. The NCVHS instead recommends that the standardized national payer identifier based on the National Association of Insurance Commissioners (NAIC) identifier continue to be used.

The enforcement discretion announced by OESS will allow HHS to review the NCVHS's recommendation and consider any appropriate next steps.

