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September 12, 2014

TO: Board of Trustees, UA Local 467 Health, Welfare, and Vacation Plan ("Plan")

FROM: Richard K. Grosboll and Lois Chang, Trust Counsel

RE: **New Health Plan Identifier (HPID) & Certification Requirements**

Pursuant to the Affordable Care Act, the Department of Health and Human Servicers ("HHS") has issued final and proposed regulations that apply to group health plans, such as the U.A. Local 467 Health, Welfare Plan, under the HIPAA privacy and security rules. As such, both insured and self-funded health plans are required to **(1)** obtain a Health Plan Identifier (*by November 5, 2014* for large plans and *November 5, 2015 for small plans*) and **(2)** file a certification with HHS attesting that the Plan is in compliance with the HIPAA standard transactions requirements (*by Dec. 31, 2015* regardless of plan size). **For the HMO benefits, Kaiser is responsible for obtaining the HPID. For the self-funded medical benefits, the Board of Trustees is responsible for obtaining the HPID. We believe a separate HPID is not required for the Plan's vision and dental benefits (considered a Sub-health plan).**

I. NEW REQUIREMENT TO OBTAIN HEALTH PLAN IDENTIFIER (HPID)

A. What is the HPID?

The Department of HHS issued final regulations establishing a standard for a National Unique Health Plan Identifier ("HPID") and provisions for implementation of the HPID. The HPID is a ten digit code that all health plans, regardless of size, must begin using to identify health plans in standard electronic transactions, starting **November 7, 2016**. NOTE: Non-health plan entities, such as a Third Party Administrator ("TPA") or Claims repricer are permitted but not required to obtain a separate identifier, known as an Other Entity Identifier (OEID).

B. What is the HPID used for?

- **Required Uses**. Once an HPID is obtained it must be used by any covered entity (such as a Health Care Provider, Health Plan, and Health Care Clearinghouse) that identifies the plan in a HIPAA standard transaction. Although Business Associates are not required to obtain an HPID, the Plan should ensure that Business Associates use the Plan's HPID when conducting transactions on its behalf. HIPPA standard transactions include: health claims, benefit enrollment and disenrollment, health care payment and remittance advice, first report of injury, health care claim status, referral certification and authorization, and electronic funds transfer.
- **Permitted Uses.** The Final Rules also clarify additional uses for the HPID that are permitted but NOT required, such as on the participant's Health Insurance Card, inpatient medical records, in the Health Care Exchange, public health data reporting purposes, or in internal files.

C. When must health plans obtain the HPID?

- LARGE HEALTH PLANS paying more than $5 million in premiums (for insured plans) or claims (for self-insured plans), for the prior plan year, must obtain an HPID by **November 5, 2014**. (We believe this Plan is a large health plan inasmuch as it has annual medical and prescription claims in excess of $5 million).
- SMALL HEALTH PLANS, paying less than $5 million in premiums or claims for the prior plan year, do not have to obtain an HPID until **November 5, 2015**.

D. Who must obtain an HPID?

- **Controlling Health Plan.** Any health plan that is a Controlling Health Plan is required to obtain an HPID. A Controlling Health Plan means "a health plan that either controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan. An entity will also be a Controlling Health Plan if it directs the business activities, actions, or policies of its Sub-health plan(s). **We interpret this to mean a Taft-Hartley multiemployer plan (such as this Plan) is a Controlling Health Plan because the Board of Trustees controls the health plans actions or policies.**
- **Subhealth Plans.** Sub-health plan are not required to obtain an HPID, but the Controlling Health Plan could obtain one on its behalf or require the Sub-health plan to obtain its own HPID. However, some uncertainty still remains since the final regulations do not clarify whether a dental or vision plan that is wrapped with a medical plan (such as this Plan's dental and vision benefits) qualifies as a Controlling Health Plan or Sub-health plan. We interpret the rules to mean that dental and vision benefits would be Sub-health plans given that they are part of the Plan and would not have to obtain a separate HPID.
  - Self-administered plans with fewer than 50 participants.

E. How to obtain the HPID?

To register and obtain an HPID, this Fund Manager will access the HHS website at ***https://portal.cms.gov*** to again entry to the Health Plan Identifier portal. The user manual with instructions on the application process is available at ***http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.***

II. FUTURE CERTIFICATION REQUIREMENT—COMPLIANCE WITH HIPAA

Earlier this year, the Department of HHS released proposed regulations requiring a Plan to meet its First Certification requirement. Under the First Certification requirement, plans would be required to file a statement with HHS certifying that the data and information systems for its health plan are in compliance with HIPAA standards and operating rules for three electronic transactions: **(1) eligibility, (2) benefit claim status, and (3) health care electronic funds transfers (EFT) and remittance advice**. The Proposed rules would require Controlling Health Plans to: (1) Report the **number of covered lives** for eligible participants and dependents covered by or enrolled in major medical policies, including the number of lives of its Sub-health plans, in the event HHS needs to assess penalties for failure to certify; and (2) Submit attestation signed by a senior level executive that it has obtained either the **HIPAA credential** or **Phase III Core Seal**. The difference between the two methods is the Phase III Core Seal requires external testing through a vendor, while the HIPAA credential does not.

A. What is the Penalty for Failing to Certify?

A penalty of $1 per covered life per day until certification is complete (with a maximum penalty of $20 per covered life) will be assessed annually for failing to certify. Where the plan knowingly or with reckless disregard provides an inaccurate or incomplete certification, the maximum penalty increases to $40 per covered life. Because penalties are based on the number of covered lives enrolled in insured major medical policies, it is unclear whether self-funded plans are subject to the penalties. We expect clarification on this issue.

Inasmuch as the certification requirement is not required until the end of next year (December 31, 2015) and the Department of HHS is still in the process of developing the certification requirements, we expect further guidance from the HHS when the final rules are released. For now, we wanted to keep you informed.

Please contact this office if you have any questions.

cc: Pam Barrett, UAS Marci Vukson, Kaufmann & Goble