HealthPlans, Inc.

Compliance Bulletin
October 6, 2014

ACA Transitional Reinsurance Program

ACA Administrative Simplification—HIPAA Standard Transaction Rules

Health Plans Identifiers (HPIDs) and Plan Certification

This Bulletin describes the actions that Health Plans' clients will need to take within the next several weeks to comply with the following regulatory requirements:

ACA Transitional Reinsurance Program

Submit plan and employer information online, and schedule payment of a fee based on covered lives

Applies to all clients

Deadline: November 15, 2014

ACA/HIPAA Standard Transaction Rules

Obtain HPIDs (Health Plan Identifiers)

Applies in 2014 only to clients with large plans, i.e., plans with more than $5 million in paid claims during the last plan year

Deadline: November 5, 2014

Applies in 2015 to all other clients

Deadline: November 5, 2015

Health Plans recently notified clients whose plan claims exceeded $5 million about their status as "large plans" and the need to obtain HPIDs by November 5, 2014. If you were notified and have questions about the information in the email, please contact your Health Plans Account Manager.

ACA Transitional Reinsurance Program

In June 2013, Health Plans summarized the requirements of the Transitional Reinsurance Program in our *Compliance Guide – Changes for 2014*. Since then the Department of Health and Human Services (HHS) has made many changes to the nuts and bolts of both the reporting and payment procedures. The modified process and clarified rules mean that Health Plans will support our clients by providing covered lives data along with information about calculating the Annual Enrollment Count. As the Contributing Entities under the Transitional Reinsurance regulations, our clients will need to register, submit plan and Annual Enrollment Count data online, and schedule payments by November 15, 2014.

To help ensure that your organization meets the November 15, 2014 deadline, your staff responsible for the submission should register at www.REGTAP.info[1] as soon as possible to review the training modules, FAQs and other tools.

- *Registration is easy*: just enter an email address and create a password.
- Then click on "Library" and "FAQs" and sort for Reinsurance-Contributions to find the tools to help complete the data submission and payment processes.

The chart below provides a recommended timetable for completing the Transitional Reinsurance Program online registration, data submission, and payment requirements by the final deadline of November 15, 2014.

2014 Transitional Reinsurance Registration, Data Submission and Payment Requirements

When	What	Who
1. Recommended by October 17	Register on www.pay.gov and www.REGTAP.info[1] and learn the steps involved in paying the Transitional Reinsurance Fee: • Determine who will be responsible for registering and submitting data to HHS • Register on **pay.gov** to establish an account if the employer does not already have an account on pay.gov (only one account per legal business entity permitted) • Register at **www.REGTAP.info** to access training presentations, tools and FAQs; find the relevant information by filtering for "Reinsurance-Contributions"	**Employer** (Employer's designated staff)

[1]REGTAP is the acronym fotr the federal Registration for Technical Assistance Portal

ACA Transitional Reinsurance Program

2014 Transitional Reinsurance Registration, Data Submission and Payment Requirements, Continued

When	What	Who
2. **Recommended by October 24**	Gather covered lives data for the first nine months of 2014 to generate the Annual Enrollment Count. (see Determining the Annual Enrollment Count, following this chart)	**Health Plans** – will provide clients with covered lives reports for January through September, as well as information about how to calculate the Annual Enrollment Count if your plan was not administered by Health Plans for the entire nine-month period **Employer** – if covered by a different TPA at any point between January 1 and September 30, 2014, contact that TPA for the covered lives data or use employer records to determine covered lives[2]
3. **Recommended by October 29**	Estimate fee due using Annual Enrollment Count. Decide whether to make one or two payments. 2014 fee[3]: $63.00 per average covered life **One installment:** Total payment due by 1/15/15 **Two installments:** 1st payment of 80% due by 1/15/15 2nd payment of 20% due by 11/15/15	**Employer**
4. **Recommended by October 31**	Confirm that ACH transfer initiated by HHS will be accepted by your bank. HHS will withdraw the contribution from the bank account on the payment date scheduled. HHS will send an email several days in advance of the withdrawal to the contact named in the Form (see #6 below). No other payment method is permitted by HHS.	**Employer**
5. **Recommended by November 4**	Access the Supporting Documentation Job Aid in the REGTAP library to create the required Supporting Documentation CSV file (see Preparing the Required Supporting Documentation, following this chart)	**Employer**
6. **Required by November 15**; recommended by November 7 in case there are any unexpected delays in the process	Log on to www.pay.gov • Access and complete ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form ("The Form") • Upload the Supporting Documentation CSV file (The fee amount will be auto-calculated and shown on your computer screen) • Schedule payment(s) when prompted for any date at least 30 days after submission, but no later than January 15, 2015[4]	**Employer**

[2] If the plan was fully insured for any period between January 1 and September 30, the insurer is responsible for reporting and paying the fee for that period, but may pass the fee on to plan sponsors either in the overall rate or as a separate fee.

[3] The fee amount for 2015 is $44.00 per average covered life; the amount for 2015 has not yet been determined.

[4] Two payments may be scheduled; the first would be due by January 15, 2014, and the second by November 15, 2015. The training materials at www.REGTAP.info include instructions on copying the completed Form to schedule the second payment.

Determining the Annual Enrollment Count

The fee payable under the Transitional Reinsurance Program is based on a plan's Annual Enrollment Count. Annual Enrollment Count is the average of covered lives (both employees and dependents) between January 1 and September 30 of each reporting year. The regulations permit self-funded plans to calculate the Annual Enrollment Count using any of three methods: Snapshot, Actual Count, or Form 5500.[5]

Health Plans will use the Snapshot Method to provide our clients with covered lives data, counting membership for each plan as of the first day of each month, January through September. Clients will receive their covered lives data for 2014 from Health Plans by October 24, 2014. The data will separately list the numbers of employees and covered dependents for each month, as well as the total covered lives for each month

- If your plan was administered by Health Plans for the entire nine-month period (January 1-September 30), the report will also show the total covered lives for the entire period, as well as the Annual Enrollment Count (calculated as total covered lives ÷ 9 months)
- Otherwise, the report will show the membership for each month the plan was administered by Health Plans, and will include instructions about how to calculate the Annual Enrollment Count depending on whether the plan was fully insured or self-funded during the months Health Plans was not the TPA.

In the meantime, clients should take action to complete Step 1 as outlined in the chart above to establish an account on www.pay.gov and access detailed guidance on www.REGTAP.info about how to:

- Complete the *ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form*,
- Upload the Supporting Documentation, and
- Schedule payment of the fee.

[5]Each method is defined in the Contributing Entities and Counting Methods Slides dated July 22, 2014 that is posted in the www.REGTAP.info Library under the Program Area Reinsurance-Contributions.

Preparing the Required Supporting Documentation

The Centers for Medicaid and Medicare (CMS) will compare the data submitted on the Form to the data submitted on the Supporting Documentation file (see #6 above), including the Annual Enrollment Count, entity's legal business name, TIN, billing address, etc. If there are differences, CMS will require correction and resubmission as applicable. The Supporting Documentation must be submitted as a CSV (comma separated value) file, and must meet detailed file specifications exactly or the entire submission will be rejected.

> To help avoid having submissions rejected, CMS will post a Supporting Documentation Job Aid on the www.REGTAP.info web site. The Job Aid is an Excel spreadsheet that permits users to enter data and then produce a correctly formatted CSV file to upload with the completed Form. The Job Aid helps promote compliance with the file specifications by alerting users to inconsistencies and errors in formatting before the CSV file is produced.

About the Transitional Reinsurance Program

As we described in our June 2013 *Compliance Guide*, the ACA Transitional Reinsurance Program was established to help stabilize premiums in the individual health insurance market from 2014 to 2016. The statute specifies that insurers in the individual, small group and large group markets, and self-insured health plans must make contributions to fund the program. The required contributions are based on the Annual Enrollment Count for each applicable calendar year (2014, 2015 and 2016). Insurers pay the fee for fully insured plans, and may pass the cost on to the plan sponsor in the premium cost or as a separate fee. Plan sponsors are the Contributing Entities for self-funded plans under the Program, and as such are responsible for paying the fee.

Health Plan Identifiers (HPIDs) and Plan Certification

Overview

Under the original HIPAA Administrative Simplification Rules, Covered Entities (providers, health plans (including self-insured health plans), and clearinghouses) were required to conduct certain transactions electronically using standard code sets. The Affordable Care Act ("ACA") imposed new requirements on plans, including standardized national Health Plan Identifiers (HPIDs) for Controlling Health Plans and certification of compliance with all the Standard Transaction Rules. The ACA also includes more detailed Operating Rules and new electronic transaction requirements for electronic fund transfers (EFTs).

HPIDs

Under the new rules, all Controlling Health Plans must obtain HPIDs to be used in the Standard Transactions (see page 8 for more information about the Transactions). Health Plans understands that our clients' medical plans are Controlling Health Plans, and as such must obtain HPIDs.[6] This requirement cannot be delegated to another entity.

The deadline for obtaining HPIDs depends on the size of the plan which, for self-funded plans, is measured by claims paid during the last full plan year:

- Large health plans (those with more than $5 million in claims paid during the last plan year) must obtain HPIDs by November 5, 2014;
- Small health plans (those with $5 million or less in claims paid during the last plan year) have until November 5, 2015.

Large Plan Notification

Health Plans has recently notified those clients whose plans we identified as being "large", with claims exceeding $5 million in the last plan year, and which will need to obtain HPIDs by November 5, 2014. If you were notified and have questions about the information in the email, please contact your Health Plans Account Manager.

[6] A self-funded plan falls under the definition of Controlling Health Plan as a plan that is controlled by an entity that is not a health plan (e.g., an employer).

Health Plan Identifiers (HPIDs) and Plan Certification

Getting Started

CMS provides instructions for obtaining an HPID at every step of the process, but here is the company information needed to begin:

- Company name
- Federal EIN
- Address
- NAIC number or payer identification number (for self-insured plans, this would be "N/A" because the number is issued by the National Association of Insurance Commissioners for fully-insured plans)

Tools and resources currently available to help large plans obtain HPIDs

Tool/Resource	Description	Available at:
Quick Reference Guide to Obtaining a Controlling Health Plan ID	Two-page overview of each step involved in obtaining an HPID, beginning with	http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPIDQuickGuideSeptember2014.pdf
HPID User Manual	Comprehensive reference manual for obtaining HPIDs, including screen shots and detailed information about what to expect at each step of the HPID process	http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html
Technical Support	Email and telephone access for answering individual questions	CMS_FEPS@cms.hhs.gov **855-267-1515**, 9 AM to 6 PM ET, Monday—Friday

To begin the HPID process, your staff should:

- Review the *Quick Reference Guide* and *HPID User Manual*
- Log on to the CMS Enterprise Portal (https://portal.cms.gov) and click "New User Registration"

Once you have obtained your HPID, you will need to provide it to Health Plans so that we may use it in the Standard Transactions we conduct on your plan's behalf (see page 8 for more information about the Transactions).

In 2015, as the HPID deadline approaches for small plans, Health Plans will update our clients with any new resources or guidance provided by CMS.

Note:
It is Health Plans' understanding that most clients would obtain one HPID to use for all medical plan options. For example, if EPO and PPO options are both offered, the same HPID would generally apply to both. However, if the client files separate Form 5500s for each option, separate HPIDs may be required. Clients may want to consult with their tax advisors on this issue.

Health Plan Identifiers (HPIDs) and Plan Certification

More about HPIDs

HPIDs are designed to increase standardization within Standard Transactions (see list below) by replacing different types of payer IDs with uniform ten-digit identifiers. The goals are to reduce errors among provider systems, such as insurance identification errors and routing errors, and to ensure more streamlined and accurate transactions.

- HPIDs must be used by November 7, 2016, whenever the health plan is identified in a Standard Transaction.
- If a health plan uses a Business Associate (such as a TPA) to conduct Standard Transactions on its behalf, the Business Associate must use the plan's HPID in the Transactions.

The Standard Transactions subject to this rule are listed below:

Eligibility* – transmission from provider to plan, or plan to plan - and their responses - related to eligibility, coverage, or benefits under the plan

Claim Status* – inquiry about status

Electronic Funds Transactions (EFT)* – transmission of any of the following from a health plan to a healthcare provider: payment, information about the transfer of funds, and payment-processing information

Electronic Remittance Advice (ERA)* – transmission of any of the following from a health plan to a healthcare provider: an explanation of benefits or a remittance advice

Authorizations and Referrals – request for authorization for health care or to refer to another provider – and response

Claims and Encounter Information – request from provider to plan to obtain payment information

Enrollment and Disenrollment – transfer of subscriber information to plan to establish or terminate coverage

Premium Payments – information about payment, fund transfer, remittance, or payment processing from entity arranging provision of care

Coordination of Benefits – transfer of claims or payment information to plan for purpose of determining relative payment responsibility

**Operating Rules have been issued*

Health Plan Identifiers (HPIDs) and Plan Certification

Plan Certification

While no action is required of any plan before December 31, 2015, the ACA requires health plans to file two certifications with the Department of Health and Human Services ("HHS") attesting that the plan is in compliance with the Standard Transaction requirements and Operating Rules.

- The first certification is for the Standard Transactions for which Operating Rules have been issued. Large health plans must file an attestation by December 31, 2015 (small plans have until December 31, 2016) to demonstrate compliance with these Standard Transactions:
  - Eligibility
  - Claim Status;
  - EFT; and
  - ERA
- The second certification for the remainder of the Standard Transactions is currently due by December 31, 2015 (December 31, 2016 for small plans); however no Operating Rules have been issued to date. Thus, this certification may be delayed.

Health plans must obtain these certifications from the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE). The certification must show that the plan performs the required Standard Transactions and has tested the Transactions with a minimum number of third parties. Plans may obtain either of two credentials from CAQH CORE:

- CORE Seal: Available by applying for the credential and successfully completing certification testing with a CORE-authorized vendor.
- HIPAA Credential: Available by applying for the credential, successfully completing required testing of the Operating Rules for the required Standard Transactions with at least 3 trading partners that collectively conduct at least 30% of transactions, and attesting to compliance with the Operating Rules.

If a plan uses a Business Associate, such as a TPA, to conduct Standard Transactions for the plan, the plan will need to ensure that the Business Associate will perform required testing with providers so that the plan can obtain certification before the applicable deadlines. Then, the plan must file its attestation with HHS that the plan has obtained certification and otherwise complies with the privacy and security rules.

Looking Ahead

- Health Plans will include our clients' HPIDs in all Standard Transactions by November 7, 2016 as required under the regulations.
- Health Plans will also complete the required testing of the Operating Rules for the required Standard Transactions in time to meet the December 31, 2015 certification deadline.

We will keep you advised of additional details as we continue to implement the HPIDs and perform the testing for certification.

Additional Information

If you have any questions about the Transitional Reinsurance Program or the HPID and certification requirements, please contact your Health Plans Account Manager.

This Bulletin is intended to provide a summary of our understanding of recent regulatory developments that may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.