



Health Care Reform

LEGISLATIVE BRIEF

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HIPAA Electronic Transaction Standards and Operating Rules

HIPAA's administrative simplification rules include standards for electronic health care transactions, which are designed to improve efficiency and reduce administrative costs throughout the nation's health care system. Health plans, health care clearinghouses and health care providers that transmit certain information in electronic form are required to comply with HIPAA's electronic transaction standards.

The Affordable Care Act (ACA) expanded HIPAA's electronic transaction standards and requires the Department of Health and Human Services (HHS) to adopt operating rules for standard electronic health care transactions. These changes are intended to improve the usefulness of electronic standards, reduce inefficient manual processes and cut costs. The ACA also requires health plans to file a statement with HHS certifying their compliance with HIPAA's standards and operating rules and to document their compliance.

The compliance dates for the ACA's changes to HIPAA's electronic transaction requirements are spread out over a three-year period. Some of the new requirements went into effect as early as Jan. 1, 2013, while others will not become effective until 2016.

STANDARDS AND OPERATING RULES

HHS has been issuing its guidance on the ACA's changes to HIPAA's electronic transaction requirements in separate parts. So far, HHS has released guidance on the health care transactions described below. More guidance is expected in the future.

Health Plan Eligibility and Claim Status

On July 8, 2011, HHS issued an [interim final regulation](#) establishing operating rules for the following two electronic health care transactions:

- Eligibility for health plan coverage; and
- Health care claim status.

The interim final regulation's operating rules became effective for health plans, health care clearinghouses and certain health care providers on **Jan. 1, 2013**. However, to reduce the potential of significant disruption to the health care industry, HHS announced that it would not initiate enforcement action until **March 31, 2013** with respect to health plans, health care clearinghouses and health care providers that are not in compliance with these operating rules.

The interim final regulation largely adopted operating rules developed by the Council for Affordable and Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE). CAQH CORE is a health industry coalition that focuses on ways to simplify health care administration for providers and health plans and health insurance issuers.

The operating rules are designed to create greater uniformity of information and transmission formats. This enables health care providers to use one type of information request for all health plans and issuers, rather than being required to implement multiple systems. For example, without the operating rules, if a physician submits an electronic inquiry to a health plan or issuer about a patient's eligibility, some plans may respond with a simple "yes" or "no," while others provide additional information the provider needs to know at the time of service, such as information about deductibles and copayments. Under the operating rules, health plans and issuers must provide detailed responses when providers ask about the status of a health care claim.

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Electronic Funds Transfers and Remittance Advice

The ACA added electronic funds transfers (EFTs) to the list of electronic health care transactions for which HHS must maintain a uniform standard. The ACA also required HHS to adopt operating rules for this new HIPAA transaction. Health plans must comply with the standards and operating rules for EFTs and electronic remittance advice by **Jan. 1, 2014**.

Uniform Standard

On Jan. 10, 2012, HHS issued an [interim final regulation](#) to establish uniform standards for health plans that use EFTs to pay providers and for health plans' electronic remittance advice. The final regulations adopt a uniform standard for the format and data content of a health plan's order, instruction or authorization to its financial institution to make a health care claims payment using EFT through the Automated Clearing House (ACH) Network.

In addition, the final regulation contains a uniform standard for electronic remittance advice. Remittance advice is a notice of payment sent to providers. It describes how the claim charges have been adjusted based on contract agreements, secondary payers, benefit coverage, expected co-payments and coinsurance and similar criteria.

Remittance advice is often provided separately from the EFT. Because the EFT and remittance advice are not linked, it may be difficult or impossible for the provider to match the payment information with the corresponding remittance advice. The final regulation addresses this problem by requiring the use of a trace number that will automatically match the payment information with the remittance advice.

Operating Rules

On Aug. 10, 2012, HHS issued another [interim final regulation](#) to adopt operating rules for making health care claim payments electronically and describing adjustments to claim payments. These operating rules are based on the CAQH CORE's set of operating rules.

The final regulation requires health plans to offer a standardized, online enrollment for EFT and electronic remittance advice. According to HHS, this requirement will make EFT and electronic remittance advice enrollment easier for health care providers because all health plan enrollment forms will be similar and they will be able to simultaneously identify and collect all the required data for multiple health plan forms. The regulation also generally requires health plans to send the EFT within three days of the electronic remittance advice to help providers reconcile their accounts more quickly.

IMPLEMENTATION TIMELINE FOR OPERATING RULES

The ACA provided an implementation timeline for HHS to adopt operating rules for HIPAA electronic transactions and for those rules to go into effect. The following chart provides an overview of these deadlines:

Transaction	HHS Regulation	Effective Date Deadline
Eligibility for health plan and health care claim status	Regulation issued July 8, 2011	Jan. 1, 2013
EFT and remittance advice	Regulation issued Aug. 10, 2012	Jan. 1, 2014
Health claims or equivalent encounter information; enrollment and disenrollment in a health plan; health plan premium payments; referral certification and authorization	Deadline for issuing regulation is July 1, 2014	Jan. 1, 2016
Health claims attachment	Deadline for issuing regulation is Jan. 1, 2014	Jan. 1, 2016

This Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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HEALTH PLAN CERTIFICATION

Under the ACA, health plans will be required to file a statement with HHS to certify that their data and information systems comply with HIPAA's electronic transaction standards and operating rules. The deadlines for the certifications are as follows:

- **Dec. 31, 2013** for the following electronic transactions: eligibility for health plan coverage; health care claim status; and EFT and remittance advice.
- **Dec. 31, 2015** for the following electronic transactions: health claims or equivalent encounter information; enrollment and disenrollment in a health plan; health plan premium payments; health claims attachment; and referral certification and authorization

In addition, a health plan must document its compliance with the HIPAA standards and operating rules and must be able to demonstrate that it conducted covered electronic transactions in compliance with HIPAA. As part of this process, health plans must provide documentation to HHS showing that they completed end-to-end testing for HIPAA covered transactions with their partners, such as hospitals and physicians. Health plans must also ensure that their business associates adhere to these certification and compliance requirements.

HHS is expected to issue more guidance on these requirements in the future.

VistaNational Insurance Group, Inc. will continue to monitor employee benefits developments and will provide updated information as it becomes available.

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