The HIPAA Standard Transaction Requirements: How do Health Plans Comply?

As most employers are aware, the federal government has released a good deal of guidance related to various provisions of the Patient Protection and Affordable Care Act ("ACA") over the recent months, including the final employer shared responsibility regulations and the final reporting regulations. Due largely to the heightened focus by employers on these complex pieces of the ACA, many other provisions of the ACA that have fast approaching effective dates have been wholly overlooked by many employers and health plans. One such important set of requirements that has not received much attention are the changes the ACA has made to the Administrative Simplification Rules under the Health Insurance Portability and Accountability Act ("HIPAA"), which include important changes to the electronic standard transaction rules (the "Standard Transaction Rules") that will require health plans to comply with certain items beginning this year.

The Standard Transaction Rules

1) Background

Pursuant to the original HIPAA Administrative Simplification rules (published in August 2000) covered entities (which include health plans) that conduct certain transactions through electronic media are required to conduct the transactions as “standard transactions” and utilize certain code sets and standards set forth by the Secretary of the Department of Health and Human Services ("HHS"). Although health plans’ business associates are often responsible for the plans’ compliance with these requirements (i.e. ensuring that the transactions covered by these rules are completed as “standard transactions”), with the changes to these rules under the ACA, health plans will now have certain responsibilities of their own.

The Standards Transaction Rules only apply to certain electronic transactions. It is important to note that unlike the HIPAA Privacy and Security rules, this section of HIPAA applies to any covered standard transaction even if such transaction does not involve the use or disclosure of protected health information. The following are the specific types of transactions to which the Standard Transaction Rules apply:

- health claims or equivalent encounter information;
- health claims attachments;
- enrollment and disenrollment in a health plan;
- eligibility for a health plan;
- health care payment and remittance advice (see below for change to this under the
ACA);
- health plan premium payments;
- first report of injury;
- health care claim status; and
- referral certification and authorization.

2) Changes to the Standard Transaction per the ACA

The ACA amended the list of standard transactions from its original form by changing the “health care payment” transaction to the new “health care electronic funds transfer (‘EFT’) and remittance advice” transaction to expand it to include both the EFT payment itself (through an Automated Clearinghouse Network) as well as any transmission where a health plan electronically provides remittance advice to explain a payment to a provider (e.g. an EOB).

The ACA also required HHS to adopt a single set of “operating rules” for each covered standard transaction for the ultimate goal of providing guidance on how the different types of information should be transmitted. These operating rules address issues like security, the format of the transmissions, how errors should be resolved, etc. The operating rules have staggered effective dates that range from January 2013 through January 2016. In general, health plans must be in compliance with the operating rules by the dates listed with the transactions below:

- Eligibility for a health plan and health care claim status – January 1, 2013
- EFT and remittance advice – January 1, 2014
- Health claims or equivalent encounter information; enrollment and disenrollment in a health plan; health plan premium payments, referral certification and authorization; and health claims attachments – January 1, 2016
- First Report of Injury – to be determined (operating rules have not yet been adopted)

What Health Plans Must Do

In spite of the fact that health plans may not even be the entities actually responsible for the performance of a majority of the standard transactions, health plans themselves do have some obligations under the Standard Transaction Rules to demonstrate their compliance.

1) Obtain a HPID

Based on the final regulations issued by HHS in September 2012, every “controlling health plan” (“CHP”) must obtain a national unique health plan identifier (“HPID”), a ten-digit code that will be used to identify health plans in standard electronic transactions. A “sub-health
The regulations allow for flexibility for SHPs and should be consulted for guidance based on individual circumstances. Under these regulations, large health plans must obtain an HPID by November, the large majority of plans will be considered large health plans under these rules, as the definition of “small health plan” is very limited since it is not based on employee or participant count. Though plans must obtain their HPIDs by 2014 or 2015, as applicable, covered entities (and business associates) do not have to begin using these codes when they identify a health plan in a standard transaction until November 7, 2016. In addition, the regulations provide for an identifier (an “OEID”) for non-health plan entities that may need to be identified in a standard transaction (e.g. a TPA). Though the OEIDs are not required, it is likely that some health plans may require certain of their business associates to use them. Information and steps for completing the application process for HPIDS and OEIDs can be found on the CMS website at https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

**Definitions**

- **CHP** – 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. Based on this definition, an employer’s self-insured plan will likely qualify as a CHP. For employers with insured health plans, the health insurance issuer will likely be the CHP responsible for providing the certification.
- **SHP** – a health plan whose business activities, activities or policies are directed by a CHP
- **Small health plan** – a health plan with annual receipts of $5 million or less

**2) Certify Compliance**

The ACA also requires that CHPs (on behalf of their SHPs) file two separate certifications with HHS to attest that they are complying with the Standards Transaction Rules. The first certification was initially required to be filed by December 31, 2013, but this effective date was delayed by subsequent regulations until December 31, 2015. This new deadline applies to all CHPs other than those considered “small health plans” that have a delayed effective date to obtain their HPID. The first certification requires an attestation of compliance with the eligibility, claim status, and EFT and remittance advice transactions. The second certification is supposedly also required to be filed by December 31, 2015; however, this may well be delayed similar to the first certification once regulations are issued regarding this certification. The second certification requires an attestation of compliance with the remaining transactions (again, other than the “first report of injury” transaction).
In general, each CHP will have two options to document compliance with the Standard Transaction Rules, and both options will be administered by the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (“CAQH CORE”). These methods are known as the “HIPAA Credential” or “Core Seal,” the specifics of which should be evaluated by health plans to determine which method is best for them. Note that there is likely a fee associated with this filing; however, such fees will vary depending on the type of health plan and/or the annual revenue of the plan. Also, keep in mind that these certifications are only to be filed once and are not an annual requirement.

Penalties for Noncompliance

HHS is required to conduct audits to verify health plans’ compliance with the Standard Transaction Rules. If a health plan is deemed to not be in compliance, HHS can assess a penalty fee for this noncompliance. The fee is based on the number of covered lives and is set at 1$ per covered life until the certification is complete, to a maximum of 20$ per covered life. However, a higher maximum penalty can apply if the plan knowingly provides false or incomplete information.

Timeline Review

- If any standard transaction is applicable to your plan, ensure you comply by the dates listed above (2013-2016); verify that your business associates are also in compliance
- Apply for and obtain a HPID for your CHP and any applicable SHP by November 5, 2014 (unless your plan meets the limited requirements for a small health plan under the regulations)
- Document second certification with Standard Transaction rules by December 31, 2015 or any such later date determined by HHS

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