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HHS Releases First Administrative Simplification Rules Under PPACA Involving Electronic Health Transactions

January 1, 2013 Compliance Date

The Department of Health and Human Services (HHS) has issued an interim final rule based on Section 1104 of the *Patient Protection and Affordable Care Act (PPACA)* that is designed to simplify and streamline administrative aspects of the health system. The rule puts operating rules into place for two electronic health care transactions, making it easier for providers to determine:

- Whether a patient is eligible for coverage; and
- The status of a health care claim submitted to a health insurer.

Section 1104(b)(2) of the *PPACA* required the adoption of operating rules for the health care industry and directed HHS to ''adopt a single set of operating rules for each transaction …with the goal of creating as much uniformity in the implementation of the electronic standards as possible.''

The compliance date of this new rule for covered entities (health plans, health care clearinghouses and health care providers) is January 1, 2013.

The rule, as published in the *Federal Register,* is available at: *http://www.gpo.gov/fdsys/pkg/FR-2011-07-08/pdf/2011-16834.pdf* or by *"clicking here."* The January 1, 2013 compliance date for this rule is different from the January 1, 2012 compliance date for covered entities to use, among other things, the ASC X12 Version 5010 standard for the electronic health care transactions. The 5010 rule was adopted in final form in 2009. See *Research Memo 2008-41* for background on the 5010 rule and the final 5010 rule at: *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf.* Both rules concern different aspects of electronic health care transactions.

The new rule largely adopts operating rules developed by the Council for Affordable and Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE), a health industry coalition that focuses on ways to simplify health

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care administration for plans and providers. CAQH CORE offered a set of potential operating rules that are currently in use in the health care industry on a voluntary basis, and which have demonstrated a significant return on investment.

According to the HHS, the rules are intended to provide greater uniformity of information and transmission formats so that physicians and other health care providers can use one type of information request for all insurers rather than being required to use multiple systems. HHS notes that if a physician submits an electronic inquiry to a health plan about a patient's eligibility, some plans may simply respond yes or no, while others provide information that the physician needs to know at the point of service, such as patient co-pays and deductibles. Under the rule, physicians will get a more detailed response when they ask about the status of a claim they have submitted to a health plan.

HHS estimates that the new rules will save an estimated $12 billion for physicians, other health providers and health insurance companies by reducing transaction costs in the form of fewer phone calls between physicians and health plans, lower postage and paperwork costs, fewer denied claims for physicians, and a greater ability to automate health care administrative processes.

The rule is the first in a series of administrative simplification steps. According to HHS, future rules will address the adoption of:

- Standards and operating rules for electronic funds transfer and remittance advice;
- A standard unique identifier for health plans;
- A standard for claims attachments; and
- Requirements that health plans certify compliance with all HIPAA standards and operating rules.

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