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HEALTH LAW ALERT
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HHS Adopts "Operating Rules" for Standard Transactions

Detailed Rules Require Eligibility Dates, Deductible Balances

Today, the Department of Health and Human Services (HHS) published an amendment to the HIPAA Transactions Rule requiring health plans and other covered entities to conduct standard transactions in accordance with 11 "operating rules" the agency has adopted. The operating rules, covering over 140 pages, establish requirements that health plans must meet when conducting standard eligibility and claims status transactions. The operating rules will require health plans to respond to electronic inquiries from health care providers concerning the eligibility of a patient with details such as the patient's dates of eligibility, financial responsibility for various benefits (*i.e.*, copays or coinsurance for hospital, office visits, emergency, chiropractic, and other services), and the patient's remaining deductible balance. Health plans will also be required to use a standardized format for their companion guides, and meet stringent response-time, and system down-time requirements.

The Affordable Care Act requires HHS to adopt "operating rules" for standard transactions. "Operating rules" are designed to "define the rights and responsibilities of all parties" to a standard transaction, and address issues such as "security requirements, transmission formats, response times, liabilities, exception processing, [and] error resolution." When these operating rules go into effect on January 1, 2013, they will apply only to "eligibility for a health plan" transactions (270/271) and "health care claim status" transactions (276/277). HHS will adopt operating rules for other standard transactions in the future. The operating rules do not affect prescription drug transactions subject to the NCPDP standards, which "provide[] enough detail and clarity" to make operating rules unnecessary.

The amendment to the Transactions Rule is published at 76 *Federal Register* 40458 (click here). Comments on the adoption of the operating rules are due on or before September 6, 2011. Click here for my compilation of the HIPAA Administrative Simplification Rules incorporating the amendment (*see* second line under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). Click here for the operating rules.

Responses to Eligibility Inquiries

Currently, health plans are required to respond to an electronic eligibility inquiry with no more than a simple "yes, the patient is eligible under the health plan" or "no, the patient is not eligible." Under the operating rules adopted by HHS today, health plans will be

required to provide much more detailed responses. For example, in response to eligibility inquiries, health plans will be required to provide the following information:

- The dollar amount and current balance of an enrollee's deductible for each of more than 40 types of services (*e.g.*, chiropractic, hospital inpatient, hospital outpatient, emergency services);
- Different deductible amounts, including current balances, for individual and family coverage (if applicable) for each of more than 40 types of services;
- An enrollee's coinsurance or copayment responsibility for each of more than 40 types of services;
- Different in-network and out-of-network coinsurance or copayments (if applicable) for each of more than 40 types of services;
- An enrollee's eligibility dates ranging from 12 months in the past to the end of the current month;
- Responses to eligibility requests each of 51 specific types of services; and
- Different deductibles for in-network and out-of-network coverage (if applicable) for each of more than 40 types of services.

System Response and Down Times

The operating rules will require health plans to respond to at least 90% of "real time" transactions within 20 seconds and at least 90% of batch transactions no later than 7:00 am of the business day following receipt of an eligibility or claims status inquiry (provided that the inquiry is submitted by 9:00 pm of the previous business day). Both real time and batch transmission systems will have to be available to conduct transactions 86% of the time.

Companion Guides

Health plans that publish "companion guides" will be required to use a standard format for their eligibility for a health plan (270/271) and health care claims status (276/277) companion guides. The guides will permit plans to publish connectivity instructions, contact information for technical assistance, and a description of "acknowledgments" the health plan chooses to use.[1] A health plan may also include in its companion guide a trading partner agreement and business rules, such as rules related to billing for specific services. Nevertheless, health plans must use the standard operating rule format for their guides.

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[1] "Acknowledgments" are short transactions that acknowledge receipt of a standard transaction.

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