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LEGAL ADVICE FOR HEALTH PLANS

HEALTH LAW ALERT
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HHS Proposes Administrative Simplification Compliance Certification Rule

First Certification Not Due for Nearly Two Years

Today the Department of Health and Human Services (HHS) published proposed rules for a process under which health plans must certify their compliance with the HIPAA Transactions Rule (including operating rules) with respect to certain transactions. The Affordable Care Act requires that health plans provide the certification by December 31, 2013, but the proposed rule would allow plans to provide the "submission requirements" as late as December 31, 2015—two years after the statutory deadline. The delayed certification date is due, in part, to HHS's desire to facilitate "the health care industry's smooth transition to ICD-10" compliance, which "is of paramount importance."

HHS will rely on a nonprofit organization—CAQH CORE[1]—to administer the certification process. The certification process will apply to the eligibility for a health plan, health claim status, and health care payment and remittance advice (including electronic funds transfers or EFT) transactions.

Most health plans would need to meet the submission requirements no later than December 31, 2015. The proposed rule would allow health plans to meet the submission requirements in either of two ways. First, a health plan could obtain CORE certification, a process that involves testing by an outside entity and compliance with standards in addition to those required by HIPAA. Alternatively, a health plan could obtain a "HIPAA Credential" from CORE—the process for which is still being developed.

Under the Affordable Care Act, HHS may assess penalties of up to $20 per covered life for failure to comply with these requirements, with penalties doubling for a health plan that knowingly provides inaccurate or incomplete information in the certification process.

[1] CAQH is the Council for Affordable Quality Healthcare. CAQH's Committee on Operating Rules for Information Exchange—CORE—established the operating rules that HHS adopted for various standard transactions.

The proposed rule is published at 79 *Federal Register* 297 (click here). Comments on the proposed rule are due no later than March 3, 2014.

Background

The Affordable Care Act requires a health plan to "file a statement with [HHS], in such form as [HHS] may require, certifying that the data and information systems for [the health] plan are in compliance with any applicable standards . . . and associated operating rules . . . for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice" transactions. Under the statute's certification requirements, a health plan must provide "adequate documentation of compliance," including evidence that it "conducts the electronic transactions . . . in a manner that fully complies with the regulations" and that the health plan "has completed end-to-end testing for such transactions with [its trading] partners, such as hospitals and physicians." The Affordable Care Act also requires a health plan to ensure its business associates' compliance with Transactions Rule standards and operating rules.

Submission Requirements

The proposed rule relies on a distinction between "controlling health plans" and "subhealth plans" that HHS established for purposes of the Health Plan Identifier Rule. A "controlling health plan" is a health plan that either (a) controls its own business activities, actions, or policies or (b) is controlled by an entity that is not a health plan. A "subhealth plan" is a health plan whose business activities, actions, or policies are controlled by another health plan. Thus, an insurer that owns and operates an HMO might be a "controlling health plan," whereas the HMO might be a subhealth plan. (Click here for my health law alert on the subject.)

The proposed certification process would require "controlling health plans" to submit two things to HHS: (1) the number of lives covered by the health plan (including the number of lives covered by any "subhealth plan") and (2) evidence of either CORE certification or a HIPAA Credential issued by CORE. The rule would not apply directly to subhealth plans. HHS plans to collect information on the number of covered lives in case "circumstances require [HHS] to calculate penalty fees," which are based on the number of a health plan's covered lives.

Core Certification. CORE awards "Certification Seals" to health plans (and other entities) that conduct electronic transactions for which CORE has established Operating Rules. As CORE explains, "Certification means an entity has demonstrated that its IT system . . . is operating in conformance with applicable requirements of . . . the CAQH CORE Operating Rules." Health plans that seek CORE Certification must comply with all CORE requirements, including some that are not required by HIPAA. For example, health plans that are CORE certified must conduct "acknowledgment" transactions in compliance with CORE Operating Rules, whereas the HIPAA Transactions Rule does not require health plans to conduct such transactions.

To obtain CORE Certification, a health plan must:

- Conduct a "gap analysis in order to determine what system and business process changes may be necessary" to meet the CORE requirements;
- Provide a "CORE Pledge," in which an executive-level employee agrees on behalf of the health plan to meet CORE standards; and
- Undergo testing on all applicable Operating Rules by a CORE-authorized testing vendor.

A health plan must pay CORE a fee for the certification, which currently may be as much as $18,000 (based on the size of the health plan). In addition, a health plan may be required to pay a fee to the CORE testing vendor, although HHS explains that, "[a]s of this writing, the . . . CORE-authorized testing vendor does not charge a fee for [testing]."

HIPAA Credential. CORE has not finalized its "HIPAA Credential" process. But, HHS provides a general outline of the process in the preamble to the proposed rule. The process would require signing an attestation that the health plan has conducted successful testing for the relevant transactions with its trading partners. Specifically, the health plan would be required to attest that it has conducted testing with trading partners that collectively account "for at least 30 percent of the total number of transactions conducted with providers," including a minimum of three trading partners. The health plan would be required to list up to 25 of those trading partners and provide name, phone number, and e-mail address for each of the listed trading partners. Costs to obtain the HIPAA Credential are estimated to be from $100 (for small health plans) to $4,000 for larger plans.[2]

Business Associates. The proposed rule would not apply directly to a health plan's business associates. Rather, "by virtue of meeting the [submission requirements described above]," a controlling health plan would "be certifying that its, and its [subhealth plans', business associates] are compliant with the HIPAA standards and operating rules." Accordingly, a health plan would have to ensure that any business associate conducting the relevant electronic transactions on its behalf (*i.e.*, eligibility for a health plan, health care claims status, remittance advice and EFT transactions) conducts the transactions in compliance with applicable standards and operating rules.

Compliance Deadline. Compliance with the certification requirements would be tied to the date on which a health plan obtains its health plan identifier (HPID). Health plans that obtain an HPID before January 1, 2015 would be required to meet the certification submission requirements between January 1, 2015 and December 31, 2015. Other than "small health plans—health plans with annual receipts of $5 million or less—

[2] The proposed rule's preamble lists likely fees for health plans with net annual revenue of between $50 and $75 million as being $4,000. It does not provide a cost for health plans with annual net revenue of over $75 million.

health plans that are currently in existence must obtain an HPID by November 5, 2014. Accordingly, currently existing plans with annual receipts of over $5 million would be required to comply with the certification requirements by the end of 2015. Small health plans and newly-established health plans that obtain HPIDs after January 1, 2015 would have 365 days from the date on which they obtain an HPID to submit the certification submission requirements to HHS.

HHS does not propose to impose certification requirements on health plans established on or after January 1, 2017, as "[t]here are too many unknowns that far into the future for us to establish requirements."

Flexible Spending Arrangements and Other Small Health Plans

The proposed rule does not address how Flexible Spending Arrangements, Health Reimbursement Arrangements, Wellness programs, and other offerings that may qualify as "health plans" under the HIPAA Rules can comply with the compliance certification mandate. Such entities generally do not conduct the relevant transactions and so cannot meet either the CORE Certification or the HIPAA Credential standards. Indeed, HHS asserts that "very few health plans meet the definition of a small health plan," suggesting that HHS has not considered application of the certification requirements to FSAs, HRAs, and other small health plans.[3]

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[3] Although some FSAs (for example) might qualify as subhealth plans that would not be required to submit information to HHS under the proposed rule, many such plans would be required to comply because they are "controlling health plans" in that they are "controlled by an entity that is not a health plan"—*i.e.*, the employer that sponsors the plan.