ACA NEWS & NOTES

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Administrative Simplification

Not just an ACA compliance feature

Administrative Simplification (AS) processes pre-date the Affordable Care Act (ACA) -- extending back to HIPAA implementation requirements. With ACA there are new AS procedures that must be incorporated. It is critical to recognize that the new requirements apply to all HIPAA defined covered entities: now including both fully-insured and self-funded major medical plans, as well as vision, dental, fixed indemnity, HIP, GAP, etc.*

FTJ has been monitoring ACA implementation. In this context, it is important we provide current information on Administrative Simplification, so that you can prepare for compliance, if indicated.

On January 2, 2014, HHS published ***Administrative Simplification: Certification of Compliance for Health Plans; Proposed Rule.*** The comment period was scheduled to close March 3rd, but was extended to April 3, 2014, due to the significance of concerns raised over the inclusion of self-funded plans and their administrators. If publication follows normal protocol, the final rule may be expected sometime this summer. Of course, we will keep you abreast of developments as they roll out.

RATIONALE

AS aligns with a generalized trend to move toward the exclusive use of secure electronic transactions for the exchange of private health information and payment for health goods and services. It is also intended to support tracking initiatives for various aspects of health care delivery.

CURRENT UNDERSTANDING

The new procedures assume compliance with all previously established HIPAA-related AS requirements. The 2014 requirements incorporate the use of a unique Health Plan Identifier (HPID), which is akin to a Tax Payer ID number, for each health plan; adds to existing credentialing standards; and most importantly, mandates end-to-end testing of specified electronic transactions between Trading Partners.

Compliance is divided into three basic phases.

Phase I – HPID Acquisition

An application for a HPID is available online through the Health Plan or Other Entity Enumeration System (HPOES), housed within CMS.

Information required for the application process, includes:

- The Company's Legal Name
- Federal ID Number
- Incorporated State
- Domiciliary Address
- The Health Plan's NAIC Number or Payer ID Number (typically used for standard transactions)

* *A limited exception only applies to the following benefits: coverage only for accident, or disability income insurance, or any combination, thereof. Liability insurance, including general liability and automobile liability insurance. Coverage issued as a supplement to liability insurance. Workers' compensation or similar insurance. Automobile medical payment insurance. Credit-only insurance. Coverage for on-site medical clinics.*

Once the application is approved, the system generates a unique HPID, and an email notification will be sent to the submitter user. Obtaining a HPID is the first step toward compliance with the rule.

Phase I Deadline:
Application must be submitted by November 5, 2014.

Phase II – Credentialing

Phase II and Phase III overlap somewhat, as to complete all credentialing requirements, the entity must demonstrate proficiency with testing procedures. However, it is clear that entities must begin the credentialing process as the next step toward compliance.

Health plans may obtain either a HIPAA Credential or a Phase III CAQH Core Seal. There are various considerations and fees associated with each choice. Fee schedules are largely based on the net annual revenue of the health plan, and are outlined in the proposed rule.

Phase II Deadline:
365-days after the acquisition of the HPID

Phase III – End-to-end Testing, Attestation and Reporting Procedures

According to the Proposed Rule, a Controlling Health Plan (CHP) must demonstrate completion of successful end-to-end testing with Trading Partners.

- A Controlling Health Plan is defined as a health plan that controls its own business activities, actions or policies. For our purposes, a CHP equates to a HIPAA covered entity (as described above).
- Trading Partner was not specifically defined, but other publications seem to indicate that these partners are providers. It remains to be seen if the final rule will provide greater clarity for this term.

To meet the deadline (noted in Phase II, above) a CHP must demonstrate compliance with three types of electronic transactions.

1. Health Plan Eligibility
2. Claims Status
3. EFTs

By November 7, 2016, all HIPAA standard e-transactions (including additional claims information; enrollment and disenrollment; premium payments; claims attachments; referral certification and authorizations) must be successfully tested.

At present for eligibility, claims status and EFTs, the CHP must provide to HHS (in a form that has yet to be determined):

> *Attestation, in which the CHP confirms that it has successfully tested the operating rules for the eligibility for a health plan, health care claim status, and health care electronic funds transfers (EFT) and remittance advice transactions with trading partners.* ***For each of the three transactions, the CHP must confirm that the number of transactions conducted with those trading partners collectively accounts for at least 30 percent of the total number of transactions conducted with providers. For each of the three transactions, the CHP must confirm that it has successfully tested with at least three trading partners, but if the number of transactions conducted with three trading partners does not account for at least 30 percent of the total number of transactions conducted with providers, the CHP could confirm that it has successfully tested with up to 25 trading partners. The CHP would have to list those trading partners.***

Testing parameters for the remaining HIPAA standard transactions will be outlined at a later time.

PENALTIES

All HIPAA covered entities (or CHPs) must comply with this rule; however, penalties are based the number of covered lives, **for major medical policies only.** The penalty amounts to $1 per covered life per day…until certification is complete.

NEXT STEPS

There have certainly been delays with implementation of ACA; however, the law continues to move forward. FTJ will continue to monitor developments and communicate with our clients on relevant changes and deadlines. For additional ACA updates, visit www.meuhp.com and click on the Health Care Reform page.

FTJ BENEFIT SOLUTIONS

FTJ has the proven ability to provide efficient and sustainable employee benefit and retirement savings programs through our work with over 200 employer clients—including assistance with pertinent ACA issues and strategies. For additional information on our services, please contact your Regional FTJ Representative or Dale Johnson at 800-821-7303, ext. 1440, or email djohnson@ftj.com.