OVERVIEW

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010 and included several administrative simplification provisions that advanced electronic administrative standards. These ACA requirements complemented the existing Health Insurance Portability and Accountability Act (HIPAA) regulations by expanding the number of electronic transaction standards and adding business operating rules, all with the goal of continuing to reduce administrative costs and improving data exchange.

SECTION 1104: ADMINISTRATIVE SIMPLIFICATION

Electronic Funds Transfers

The ACA added the electronic funds transfers (EFT) transaction to the list of electronic transactions to be adopted as a standard under HIPAA. In general, an EFT is used by a health plan to pay health care claims and is transmitted through the Automated Clearing House (ACH) Network. The following standard and associated operating rules were mandated for use effective January 1, 2014:

- The National Automated Clearing House Association (NACHA) Corporate Credit or Deposit Entry with Addenda Record (CCD+) implementation specifications as contained in the 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network as follows:
    - NACHA Operating Rules, Appendix One: ACH File Exchange Specifications
    - NACHA Operating Rules, Appendix Three: ACH Record Format Specifications, Subpart 3.1.8 Sequence of Records for CCD Entries

Since the compliance deadline, over three quarters of the industry has adopted the electronic EFT transaction standard, according to the most recent 2025 CAQH Index Report. This adoption rate has remained steady over the last three years and there is room for additional savings by organizations that have not yet implemented the EFT standard.

Operating Rules for Health Information Transactions

“Operating rules” are defined in ACA as the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications. The Secretary of the Department of Health and Human Services (HHS) was to adopt a single set of operating rules for each transaction for the necessary business rules with the goal of creating as much uniformity in the implementation of the electronic standards as possible.

The CAQH Committee on Operating Rules for Information Exchange (CORE) was designated as an operating rule authoring entity and developed the following operating rules:

- Eligibility for a health plan
  Effective date: January 1, 2013

- Phase I CORE 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011
- Phase I CORE 153: Eligibility and Benefits Connectivity Rule, version 1.1.0, March 2011
- Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule, version 1.1.0, March 2011
- Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule, version 1.1.0, March 2011
- Phase I CORE 156: Eligibility and Benefits Real Time Response Time Rule, version 1.1.0, March 2011
- Phase I CORE 157: Eligibility and Benefits System Availability Rule, version 1.1.0, March 2011
- Phase II CORE 258: Eligibility and Benefits 270/271 Normalizing Patient Last Name Rule, version 2.1.0, March 2011
- Phase II CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule, version 2.1.0, March 2011
- Phase II CORE 260: Eligibility & Benefits Data Content (270/271) Rule, version 2.1.0, March 2011
- Phase II CORE 270: Connectivity Rule, version 2.2.0, March 2011
- CORE v5010 Master Companion Guide Template, 005010

- Health claim status transactions
  Effective date: January 1, 2013
  - Phase II CORE 250: Claim Status Rule, version 2.1.0, March 2011
  - Phase II CORE 270: Connectivity Rule, version 2.2.0, March 2011

- Health care electronic funds transfers (EFT) and remittance advice transaction
  Effective date:
  - Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June 2012, except Requirement 4.2 titled "Health Care Claim Payment/Advice Batch Acknowledgement Requirements"
  - Phase III 360 CORE Uniform Use of CARCs and RARCs (835) Rule, version 3.0.0, June 2012
  - CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, version 3.0.0, June 2012
  - Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, version 3.0.0, June 2012
  - Phase III CORE 380 EFT Enrollment Data Rule, version 3.0.0, June 2012
  - Phase III CORE 382 ERA Enrollment Data Rule, version 3.0.0, June 2012
  - CORE v5010 Master Companion Guide Template, 005010

Operating rules for: (i) Health claims or equivalent encounter information; (ii) Enrollment and disenrollment in a health plan; (iii) Health plan premium payments; and (iv) Referral certification and authorization transactions have not yet been mandated through final regulation. Additional operating rules have been developed by CORE and are available for voluntary adoption.

Claims Attachments

While the requirement to adopt an electronic transaction standard for claims attachments was included in HIPAA, regulation mandating a standard had not been promulgated. The ACA included a provision requiring a standard and associated operating rules be adopted and effective not later than January 1, 2016. While this timing requirement was not met, CMS did publish the Claims Attachments and Electronic Signatures final rule on March 24, 2026.

SECTION 10109: DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS

This section of the ACA set requirements for developing additional transactions and operating rules. The Secretary of HHS was to solicit input not less than every 3 years on whether there could be greater uniformity in financial and administrative activities and if those activities should be considered for adoption as standards or operating rules. The Secretary was to seek input from the National Committee on Vital and Health Statistics and the Health Information Technology Policy Committee and the Health Information Technology Standards Committee (later replaced by the Health Information Technology Advisory Committee), along with standard setting organizations and stakeholders.

Among the items to be considered were the potential for: (i) Standardizing an electronic application form for enrollment of providers by health plans; (ii) Including property and casualty insurance and other non-covered entities under HIPAA; (iii) Standardizing forms for health plan audits; (iv) Creating greater transparency and consistency of claim edits used by health plans; and (v) Requiring health plans to publish their timeliness of payment rules. While there has been discussion on these topics over the years, no specific requirements have been mandated through regulations.

RESOURCES

- CAQH Operating Rules
- CMS: Operating Rules Overview
- CMS: Operating Rules for Eligibility and Claim Status
- CMS: Operating Rules EFT and Remittance Advice
- CMS: Operating Rules FAQs
- Nacha
- CMS: EFT and ERA: Electronic Funds Transfer and Electronic Remittance Advice Transactions Basics
- CMS Administrative Simplification webpage