



ABOUT ADMINISTRATIVE SIMPLIFICATION

Health Plan Eligibility and Benefits Transaction Basics

What is a Health Care Transaction?

A health care transaction is an exchange of information between two parties to carry out financial or administrative activities. When electronic transactions are used effectively in health care, they:

- Increase efficiencies in operations
- Improve the quality and accuracy of information
- Reduce the overall costs to the health care system

Widespread use of Healthcare Insurance Portability and Accountability Act of 1996 (**HIPAA**) **adopted transactions**—where everyone uses the same language, format, and code sets—can lead to substantial savings across the health care industry. To realize these benefits, however, all organizations need to be using the same adopted standards for their transactions.



Eligibility and Benefits Transaction

The health care **eligibility and benefits inquiry and response transaction** covers inquiries and responses about a patient's eligibility for insurance benefits, including information like copays and deductibles.



Adopted Standards

As part of **Administrative Simplification**, HHS adopted a standard for the eligibility and benefits transaction that has two parts:

- The request transaction, known as the X12 5010 270 transaction for inquiries about eligibility and benefits, which can be sent from a health care provider to a health plan, or from one health plan to another
- The response transaction, known as the X12 5010 271 transaction for health plan responses to inquiries about eligibility/benefits

These standards apply to all **HIPAA-covered entities**—health plans (including Medicare and Medicaid), clearinghouses, and certain health care providers that conduct the adopted transactions electronically—not just those that work with Medicare or Medicaid.

For pharmacy-related eligibility/benefit inquiry and response transactions, HHS adopted the **National Council for Prescription Drug Programs** (NCPDP) Telecommunications Standard Version D.O. This standard also applies to all HIPAA-covered entities.



Operating Rules

All HIPAA-covered entities are required to adopt business rules, also known as **operating rules** for health care eligibility and benefits transactions, as of January 1, 2013.

Eligibility operating rules require health plans to respond in real time to providers' eligibility inquiries with a patient's financial information, including:

- Deductibles, copays, coinsurance, and in/out of network variances
- Coverage information for specific service types

View **CAQH CORE Eligibility & Benefits Operating Rules** for eligibility/benefits transactions.

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