Statement of Gary Beatty
On Behalf of America's Health Insurance Plans
to the
ACA Review Committee
on Medicare Supplemental Health Plans
Administrative Simplification
June 17, 2015

Introduction

Thank you for the opportunity to provide testimony before the committee today. My name is Gary Beatty and I am the Director of Medicare and EDI Strategy with UnitedHealth Group Medicare and Retirement. I have been involved with health care administrative simplification since the early 1990's from both a provider's perspective, government contractor perspective, and a health plans perspective. I am also very engaged with the standards development committees and currently serve as the vice-chair of the Accredited Standards Committee (ASC) X12. My testimony today focuses on the unique requirements relative to Medicare supplemental coverage for our 65 and over population and does not represent any position of ASC X12.

Today I am providing testimony on behalf of UnitedHealth Group in coordination with America's Health Insurance Plans (AHIP). AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis.

Overview

Medicare supplement insurance plans are uniquely different from other types of insurance in that it is insurance that is purchased from a private insurance company that pays for some or all of the cost sharing in Medicare Parts A and B coverage. This means that Medicare supplemental health plans are secondary payers to Medicare and are dependent upon Medicare's adjudication of claims to be able to determine the member's benefit. Currently, over 800 million health care claims crossover to the secondary payers per year for processing. Our testimony covers observations and recommendations related to the overall transaction and code set requirements as well as specific issues from a Medicare supplemental insurance perspective.

Observations and Recommendations

It's Time to Change: The current version of the ASC X12 transactions that are adopted are based upon version 005010. This version was published in October 2003, 12 years ago. The health care industry continues to change from both a business process perspective and from regulatory mandates which are putting stress on the transaction standards ability to support the needs of the health care industry. Given the length of time between versions it becomes very difficult to implement the amassed volume of changes that have occurred over such a long time leading to lengthy implementations and transition timelines. It is recommended to balance the number of changes and business needs with the frequency of adopting new versions to allow for more flexibility and timeliness to meet the ongoing changes within the health care industry.

Codified Data Content: One of the changes occurring at ASC X12 that will foster more flexibility in between adopted versions of the standards is the externalization of codes from the standards versions. Within the ASC X12 standards codified data content can either be internal to the ASC X12 standard and tied to a version of the standard or external codes which are referenced by the standard but maintained by either ASC X12 or other organizations and are not tied to a version of the standard. By making more codified data content external, changes can occur without requiring the adoption of a new version for administrative simplification. This will allow for more flexibility and the ability to implement changes within the health care industry on a timely basis in between adopted versions. We would like to encourage this strategy and direction by ASC X12.

Acknowledgments: Even though much of the health care industry has voluntarily adopted and implemented the EDI acknowledgments we believe it is time to mandate acknowledgments. There certainly have been many inconsistencies related to transaction acknowledgments overs the years. HIPAA regulations did not recognize or include acknowledgments at all while under the Affordable Care Act their existence was recognized in the CAQH CORE Operating Rules but then removed by Federal Regulation. There are 4 different acknowledgments that should be considered as each has its specific purpose and benefits including:

- The 999 Implementation Acknowledgments for all batch transactions (rejects only for real-time). This transaction functions much like the return receipt card from the United States Postal Service and is sent from the receiver back to the submitter of transactions letting them know they were received and didn't get lost. They also provide consistent messaging when there are syntactical errors with the transactions so they can be corrected and resubmitted.
- The TA1 is the Interchange Acknowledgment is used to acknowledge the EDI envelope that contains the external addressing information. This acknowledgment lets the submitter know if their envelop was received or not and if there were any errors a consistent set of messaging to identify the error.
- The 277 Health Care Claim Acknowledgement acknowledges each individual claim and when there are business errors with claims a standardized set of error codes describe what the error was so the provider can correct and resubmit the claim. This is an extremely

important acknowledgment since historically every health plan and clearinghouse had their own proprietary acknowledgement for claims requiring providers to interpret each payer and clearinghouses claim reports. This acknowledgement replaces all of them with a single transaction across the health care industry.

- The 824 Application Reporting for Insurance provides the same functionality as the 277 Health Care Claim Acknowledgements for all of the other transactions than the 837 health care claims.

Medicare Supplemental Health Plan concerns:

- The Health Care Eligibility (270/271) Operating Rules mandates the return of specific information relating to a patient's financial responsibility including co-insurance, deductible, and co-pay amounts. The challenge for Medicare supplemental health plans related to patient financial information is these amounts are dependent first upon how Medicare adjudicates the claim benefits. So returning meaningful patient financial information is challenging. Also, the eligibility transaction presents challenges in expressing tiered benefits and local/narrow network information. We recommend in situations of Medicare crossover claims for coordination of benefits that patient financial information not be required due to the dependence on prior payer adjudication.
- We recommend adding the Medicare Approved Amount back into the 837 Health Care Claims transactions. This amount was included in the first version of the HIPAA adopted claims implementation guides. At the time when version 005010 implementation guides were developed it was determined that this amount could be calculated and thus was removed from the 005010 implementation guides. With the recent changes to support value based health care with incentives and penalties that apply to the Medicare paid amounts or the Medicare approved amounts the ability to calculate this value has been made very difficult or impossible.
- Also associated with the changes for value based health care, Medicare crossover claims have been using a Claim Adjustment Reason Code (CARC) code 237 Legislated / Regulatory Penalty. This CARC requires at least one Remittance Advice Remark Code (RARC). The challenge with the current 005010 version of the ASC X12 837 Health Care Claim does not allow service line linkage between CARC and RARC codes. Newer versions of the ASC X12 837 Health Care Claim have been modified with a new Segment called the Reason Adjustment (RAS) which allows direct linkage of the CARC and RARC codes at both the claim level and the service line level as required by the code list and the CAQH CORE code combination requirements. This new Segment will greatly clarify the use of CARC and RARC code combinations required by the Affordable Care Act and the code combinations defined by CAQH CORE. This is another business reason why we recommend the adoption of a newer version of the adopted transactions for health care claims.
- Another challenge with the use of CARC 237 for Medicare is the use of multiple CARC 237 codes on a single claim within a single CAS adjustment segment. Using more than one occurrence of the same CARC in a CAS segment causes errors and rejections.

Clearinghouses have relaxed edits to allow these transactions to pass on to health plans. This however does not relieve the CARC and RARC linkage issue identified above.

Closing

We would like to thank you again for the opportunity to testify today on the unique requirements and recommendations for Medicare supplemental health plans in support of our members and customers and look forward to your questions.