Written Statement of Merri-Lee Stine
On Behalf of Aetna and America's Health Insurance Plans
to the
ACA Review Committee
Regarding Health Care Payment, Remittance Advice and Electronic Fund Transfer
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Introduction

My name is Merri-Lee Stine. I am a Senior Project Lead in the Provider eSolutions department at Aetna. Aetna's Provider eSolutions organization is responsible for the innovation, promotion, training and support of electronic connectivity that enables our provider community to more efficiently manage their administrative, financial and clinical interactions. Aetna is one of the nation's leaders in medical, dental, pharmacy, group life and disability insurance serving over 23.5 million members.

Today I am providing testimony on behalf of Aetna 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

My discussion today will be regarding the barriers, either perceived or actual, that have been encountered in the implementation of the standard transaction and Operating Rules for the Health Care Payment, Remittance Advice and Electronic Fund Transfer, speaking from our experience as a health plan.

I have three overall themes to discuss today regarding items that may be perceived as barriers to implementing the Remittance Advice transaction. Essentially, these items cause more work, or make the health plan's or provider's life more difficult than alternative methods of receiving the same information – such as the paper Explanation of Benefits. None of these items are impossible to overcome, but they need some work on to make the implementation and continued use of these transactions a smoother, more automated process.

The first issue, and the one we hear the most, is the number of remittances and payments that providers receive. The expectation within the remittance, and the associated payment, is that the National Provider ID of the payee will match that of the billing provider on the submitted claim unless explicit notification has been made to the payer from the provider identifying the payee and related billing NPI (reference: RFI 1559 on X12.org).

As health insurance plans, we can sometimes see options for a reduction in the number of separate payments to providers. Unfortunately, we are not able to make the decision to change how the payments are grouped on behalf of the provider- that information must come from the providers themselves.

The second issue I would like to discuss is the reporting of pending claims in the Remittance Advice. With the adoption of the version 5010 standard Remittance Advice, the ability to report pending claims was removed from the transaction. The intent with the removal was that pended claims would be reported in a separate transaction, the Health Care Claim Pending Status Information transaction, sometimes referred to as the 277P. This is different from the Claim Acknowledgement, also referred to as the 277CA transaction, which is part of the draft Claim Operating Rules you will hear other panelists discuss today. The 277P is specifically intended to report a listing of pending claims to the provider.

Health insurance plans have been discouraged from reporting pended claims in the Remittance Advice and the Pending Status transaction has not been adopted under the administrative simplification rules as a mandatory transaction. As a result, providers do not always understand the outcome of the submitted claim. While we have voluntarily implemented the Pending Status transaction, the industry use of this version of the 277 is limited and providers are largely unaware of its availability. Wider industry use would be beneficial to the industry to provide a clear and complete picture of the status of the electronically submitted claim and allow the provider to implement automated processes to address action items.

Although the reporting of pended claims was removed from the function of a Remittance Advice transaction, the existence of a code used to communicate the final adjudication of the claim in the remittance which still refers to "pending" leads to confusion. In fact, in the implementation guide, there is a specific situation that is referenced which uses the code:

> Claim Adjustment Reason Code 133 – "The disposition of this service line is pending further review." (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).

The intent of this reference is to allow balancing of the overall transaction when some service lines within a claim are paid and others are pending. I do not believe the intent of the authors of that guide is to utilize the code for generally pending claims.

The third issue for my short discussion today is the topic of code lists. The code lists used in the Remittance Advice are maintained by multiple committees – the Claim Adjustment Group Codes are maintained by ASC X12, while the Claim Adjustment Reason Codes and Remittance Advice Remark Codes are maintained by two other committees separate from ASC X12.

Each of these groups does diligent work, maintaining the lists individually, while taking the other into account as they make decisions, but there are times when a request can move from committee to committee while trying to find the most appropriate reporting mechanism for the adjustment. An additional complexity is the fact that some of the combinations of those codes

are governed by the CAQH CORE Phase III Operating Rules. When one of the maintaining committees makes a change, the CAQH CORE Codes Combinations maintenance group must react to the change as well, if the code is part of the required code combinations for compliance.

Historically, variations in how health insurance plans interpreted and applied the codes to the adjudication results of a claim has caused confusion and hindered the opportunity for automated work flows in provider systems and processes. The adoption of the set of standard code combinations maintained by CAQH CORE has been an ongoing process to create an industry wide implementation of the Remittance that is more consistent and understandable by its receivers and has made progress in this area.

We expect the CAQH CORE process will continue, but additional clarifications are needed. Work within those committees who create and maintain the codes themselves to define the codes and better describe the intent of the committee members when creating or changing a code would benefit the industry in the long term. When the originators of the Remittance Advice transaction clearly understand the intended use of the code and the receivers clearly understand how the codes should be interpreted -- both sides benefit.

Additional Industry Perspective

AHIP recently conducted a survey of its member plans to solicit broad industry perspective on the status of adopted standards and operating rules being evaluated by the ACA Review Committee. Twenty plans responded to the survey, representing major medical carriers (18), dental carriers (10), Medicare payers (10), Medicaid health plans (9), as well as plans offering long term care, behavioral health, or vision benefits (7). Most of the responding health plans (13) offer coverage in multiple states and estimated their number of covered lives ranging from under 100,000 to over 10 million (20% estimated their covered lives between 100,000 to 1 million, 20% between 3 million to 5 million, and 30% over 10 million). A summary of the responses related to the health care payment and remittance advice and electronic fund transfer transaction is below.

The majority of health plans (67%) that responded to AHIP's survey indicated that the 835 transaction meets current business needs, but the responders identified opportunities for improvements. Specifically, plans commented that the ability to associate CARC/RARCs will improve use of the transaction, which the release of the next version of the TR3 will address. Plans also raised concerns that the X21 835 and NACHA EFT formats have defined certain fields differently, thus making re-association a challenge for providers.

Plans also discussed the role of other stakeholders in adoption of the standard. Some providers resist enrolling in EFT/ERA for various reasons, including preferring paper payment options. Many health plans conduct extensive outreach and education with providers to increase EFT/ERA enrollment and our survey similarly indicated that improving the enrollment process and increasing adoption by other stakeholders would significantly improve use of the standard.

Closing

In summary, opportunities exist to help our providers to get more complete, automated use of the transaction by the provider address the issue of too many remittances and payments, lack of an electronic reporting for pending claims and a disconnect in perceived definitions used in the codes assigned on adjustments within the remittances.

We thank the Subcommittee for the opportunity to submit this testimony for the record.