BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

TESTIMONY

Before the

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

REVIEW COMMITTEE

ON

ADOPTED TRANSACTION STANDARDS, OPERATING RULES, CODE SETS & IDENTIFIERS

Presented by:

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BLUE CROSS BLUE SHIELD ASSOCIATION

June 16-17, 2015

Good morning. My name is Gail Kocher and I am a Director, National Programs, for the Blue Cross Blue Shield Association. BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 106 million members – one in three Americans – across all 50 states, the District of Columbia and Puerto Rico.

On behalf of BCBSA and its Member Plans, I would like to thank you for the opportunity to respond to the Review Committee's questions and provide our perspective on the adopted transaction standards, operating rules, code sets and identifiers. We continue to strongly support standardization, which brings value to all stakeholders within our industry.

Blue Plans vary widely in size, markets, and geography. However, despite these differences, Plans report little variation in experience for a particular transaction: the challenges and barriers to adoption of that transaction by trading partners, and the overall adoption rate of mandated standards, are fairly consistent across the Plans. Therefore, our responses to the Review Committee's questions, which have been organized in order by panel below, are applicable to Blue Plans generally.

Before addressing the Review Committee' questions, I would like to make three contextual observations that we hope the Review Committee will take into consideration as it carries out its work:

1. One barrier applicable to all transactions is the inherent distinction within Administrative Simplification of who is a covered entity and who is not, i.e. the nuance where a health care provider is a covered entity only when they choose to conduct the standard electronic transactions. This allows providers to continue to utilize paper, telephone and other non-electronic methods to conduct administrative functions such as eligibility, claims, etc. Another overall barrier is the difficulty in developing and subsequently mandating through rulemaking changes to the standards in a timeframe which meets the rate of change within the healthcare industry for emerging technologies and business models.

2. While the scope of the current hearing is on the currently adopted standards, operating rules and code sets, there was a concern that repeatedly arose in discussions with the Plans that has the potential to become a barrier to the currently adopted operating rules. This concern is the potential adoption of a next phase of operating rules. We would refer the Review Committee to BCBSA's February 2015 testimony on the proposed next set of operating rules (Attachment 1).

3. It is difficult to separate opportunities, barriers and alternatives as they are in most cases directly linked with one another. The value proposition is tied across the entire spectrum as well.

Panel 1: Health Plan Enrollment/Disenrollment and Health Plan Premium Payment

The enrollment and premium payment standards may be the one set where the value is not as directly related to opportunities and barriers as the other standards. Plans in general indicated that the value proposition would increase simply by a greater adoption of use by their trading partners. A significant barrier here is that many group health plans, especially in a fully insured model, are not themselves a covered entity and therefore moving them to the use of the 834 and 820 standards is achieved only through the contractual portion of the relationship. It is not surprising that often these employer groups do not have the technology infrastructure within their entity to implement an EDI transaction, and spreadsheets or proprietary flat files are more efficient for their business model. Many of these groups have no other business functions which utilize the ASC X12 formats and so development for an 834 or 820 is not prioritized for implementation.

Plans have indicated that the value of these transactions would increase simply by more trading partners adopting them. We urge NCVHS and HHS to examine approaches which would increase adoption thereby avoiding the maintenance associated with multiple channels of data input into enrollment systems. Multiple input channels often results in increased customization of vendor tools, which increases costs as well as impacts resources needed for implementation. Use of the HIPAA-adopted standards by all trading partners regardless of covered entity status, enables the member data protections afforded by the HIPAA privacy and security rules to flow with that data as it moves through other hands and into other uses. Data stewardship is rooted in the concept of managing the member's/consumer's expectations of confidentiality, expectations that are set and defined when the data is collected, created or possessed by a covered entity through the use of the HIPAA privacy notices. That these defined and explained privacy protections and permitted uses would continue being applied as the data moves through the healthcare information continuum is a reasonable expectation on the part of consumers and one that is better achieved through broader usage of the standard transactions through EDI channels.

The introduction of the 834 and 820 into the insurance exchange environment has been helpful but it has also presented additional challenges due to the differences between the business of traditional commercial group enrollment and the individual marketplace enrollment processes. The greater standardization that can be utilized across all enrollment processes will enable improvements to downstream processes such as eligibility inquiry responses.

Panel 2: Health Plan Eligibility, Benefits Inquiry & Response

The eligibility request and response is a transaction that provides significant value to the Plans as well as provider customers. Use of the eligibility transactions is high across all Plans, even smaller Plans. We believe that there is a relationship between lower volumes of inquiries via phone and higher volumes of eligibility transactions, although it is not a directly inverse relationship. Plans do find some providers conduct a 270 inquiry several days or more ahead of a member's scheduled appointment and then another check the day before or day of the visit. Some Plans are finding that clearinghouses are sending

eligibility inquiries prior to claim submissions in order to assist with ensuring that member data on a claim is more accurate, i.e. a cleaner claim.

Even with significant use, Plans have identified that the current standard is being enhanced for future versions to address newer models of networks and products, e.g. tiered benefits. Without the ability under the current versions to better codify new products and benefits, Plans must use more free-form text messages to communicate information, which is more difficult for provider systems to consume. In some cases, this drives up follow-up call volumes due to the limitations in the current standard. In the future, the ability to react more quickly to new products and benefits through the use of external code sets and more flexibility in the standard is a significant opportunity for the eligibility process.

Plans are also seeing greater use of the standard for non-HIPAA purposes such as member out-of-pocket estimation; however, the standard is currently not as conducive to greater use for consumer solutions. Consumer tools enable the member to electronically request their benefit information and often use the 270/271 to move the request and response from the tool to the health plan and back, but the standard was designed for use between covered entities, i.e. providers and health plans, not between a member (via a tool) and the health plan. Consumer uses of the standard and the ability to more readily accommodate them in future development is an opportunity that might be considered. While Plans have been able to work with the current standard for consumer tools, they have indicated that operating rules in some cases present challenges related to system availability since the same channels are used for both purposes.

Panel 3: Prior Authorization

This is one transaction where Plans report little to no use by providers and the value proposition for implementation is much lower. The barriers to adoption include the complexity of the transaction and the lack of an attachment standard. Prior authorizations often require a more conversational approach to exchanging information between the provider and the health plan. Initial requests may prompt follow-up “questions” which are not as readily exchanged in an EDI environment, especially when providers use the batch approach. Even when providers use a real-time approach, Plans find that some inquiries require responses which are not processable for approval in an automated real-time fashion, due to the need for medical review. While a real-time prior authorization can be a little more conversational, Plans indicate their providers find having that exchange through a web portal more convenient to their office workflows. The 278 has greater clinical data content and necessitates greater involvement by clinical staff than administrative staff to see greater benefit. Flexibility to use newer business technologies to exchange information, e.g. XML via a web portal, would accommodate the need for a more iterative process for authorizations as there is often the need for additional questions and follow-up, i.e. an ongoing exchange between the clinical staff and the health plan. This would enable the focus of EDI resources on other transactions with much heavier use by providers.

Plans do believe that adoption rates might increase when the health claim attachment standard is adopted. As we have shared previously with the Subcommittee on Standards, adopting standards for attachments that automate today's largely manual processes, has the potential to generate significant savings for all stakeholders.

Panel 4: Health Care Claim or Equivalent Encounter Information

The 837 health care claim, institutional and professional, is the transaction that we find provides the most value to Plans, provider customers and the Association. The claim is the transaction with the most use across the Plans and its data is used for adjudication of inter-Plan claims. We still find a much lower use of the 837 dental claim while both the institutional and professional claims are almost all electronic. For both institutional and professional claims, minimal submission via paper is generally a result of either providers not having electronic capabilities (e.g. rural providers with limited or no access to electronic connectivity methods) or types of claims which are not easily accommodated on an electronic claim (e.g. institutional claims with greater than 100 lines or complicated secondary claims).

The health claim attachment is both a barrier, due to lack of having a standard, and an opportunity, by adopting a standard in the future. The comments made earlier with respect to attachments and prior authorization hold true for claims as well.

While the current claim standards meet Plan needs, there are always instances of having to utilize workarounds to meet business needs. The need to report present on admission is an example of a workaround during 004010A1 that was codified in 005010. Examples of current workarounds that we anticipate will be discreetly reportable in the future are the capability to report both the repackaged and original NDC numbers and the dental readiness classification code.

Panel 5: Coordination of Benefits

Plans report that the provider-to-payer coordination of benefits approach is more valuable to focus implementation efforts on. Payer-to-payer coordination of benefits outside of the Medicare crossover process has little to no implementation and Plans indicate this is not a priority due to inherent complexities and proprietary nature involved when two payers are competitors.

Panel 6: Health Care Claim Status

The claim status transaction is another high value standard to the Plans. They indicate its use parallels that of the eligibility request and response, including seeing a reduction in phone inquiries. In general, Plans offering the 277 Claim Acknowledgement to their trading partners find the claim status transaction used less. This indicates usage of the claim status transaction as a means to determine whether a claim has been received, not necessarily to inquire on the status of the claim itself.

The most significant opportunity associated with the claim status is the mandating of the claim acknowledgement standard. This would enable a more efficient use of the claim status transaction for its intended purpose of obtaining a status of specific claims within the payer's adjudication system as opposed to its use to identify whether the claim was actually received by the payer. While we support the voluntary adoption of acknowledgements and we believe they are important support for business transactions, as we have testified previously, adoption as a HIPAA-mandated standard must occur through the federal rulemaking process. This ensures that all stakeholder impacts, needs and implementation timeframes have been considered.

Panel 7: Health Care Payment, Remittance Advice and Electronic Funds Transfer

Plans reporting significant use of the remittance advice and electronic funds transfer (EFT) see these as high value standards. Other Plans report less use by their providers, which they attribute to the mandate to adopt the 835 and EFT being applicable only to providers when they choose to conduct these transactions electronically.

Plans do report more barriers with the remittance advice related to provider behavior and operating rules. With respect to providers, it is their resistance to supplying banking information and preference for paper checks and remittances. This results in Plans continuing to supply paper checks and remittances to those providers not choosing to move to the electronic versions. Plans continue to be challenged by the Code Combination Operating Rule 360. The frequency of updates and time limitations from update to effective date is a challenge as implementing these changes for output on remittances often impacts multiple systems and the updates are often required out-of-cycle with regularly scheduled releases.

Plans would like to retain the flexibility to use for providers electing not to move to the electronic remittance and claim payment. Plans prefer that providers implement use of the 835 and EFT but see the use of credit cards as a viable alternative when providers make a choice not to use the adopted electronic standards. Use of these alternate methodologies should be based on full transparency, such as mutual trading partner agreement which gives providers advance notice before a new payment method is implemented.

CONCLUSION

BCBSA supports the adoption of standards and operating rules. We recognize their value in achieving the overall goal of quality and affordable healthcare. Affordability and quality necessitates the exchange of patient information. We recognize and promote the value of standards, operating rules, identifiers and code sets, but also recognize the need for the industry to develop timelier and more predictable maintenance cycles.

As the Review Committee is beginning its first iteration, we encourage the review and evaluation after the first cycle of the processes and criteria used before moving into a second review cycle. Looking to actual experience for feedback we believe will make the process, criteria and as a result the adopted standards and operating rules stronger moving forward.

Given the number of mandates with implementation dates in the next few years, we urge NCVHS to consult with HHS as well as the industry, on developing a strategic road map for Administrative Simplification provision implementations, which would balance all mandates from the ACA, not just Administrative Simplification provisions, along with other ARRA/HITECH mandates to avoid bottlenecks and overlapping resource commitments.

We appreciate the opportunity to testify and I would be happy to answer any questions.