Written Statement of Don Petry
On Behalf of Blue Cross Blue Shield Tennessee and America's Health Insurance Plans
to the
ACA Review Committee
Regarding Health Plan Enrollment / Disenrollment and Health Plan Premium Payment
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Introduction

My name is Don Petry and I am the Program Manager for Health Care Reformat BlueCross BlueShield of Tennessee. BlueCross BlueShield of Tennessee (BCBST) is a not-for-profit health plan founded in 1945. Today, we serve 3.4 million people across the state and around the country.

Today I am providing testimony on behalf of Blue Cross Blue Shield Tennessee 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.

My testimony will address BCBST's experience with the adoption of the health plan enrollment and disenrollment (834) transaction and health plan premium payment (820) transaction, with a focus on our experience using these transactions within the Federally-facilitated Marketplace (FFM) and Federally-facilitated Small Business Health Options Program (FF-SHOP). BCBST has participated in the FFM and the FF-SHOP since open enrollment began on October 1, 2013. BCBST currently supports the following transactions:

- Benefit Enrollment and Maintenance (834 Transaction) for Individual Market (005010X220A1),
- Benefit Enrollment and Maintenance (834 Transaction) for FF-SHOP Market (005010X220A1)
- Payment Order/Remittance Advice (820 Transaction) for FF-SHOP Market (005010X306).

BCBST is in advance testing for the following transaction, which the FFM expects to implement in production in January, 2016:

- Payment Order/Remittance Advice (820 Transaction) – Final File for Individual Market (005010X306).

BCBST does not participate in any State Based Marketplaces (SBMs) thus I will focus on our experience in the FFM and FF-SHOP. Findings from other issuers gathered by AHIP related to the use of the 834 and 820 in SBMs as well as concerns related to their use in the group market are addressed later in my testimony.

Overview

The Enrollment/Disenrollment and Health Plan Premium Payment standards on the FFM and FF-SHOP represent an evolving paradigm between barriers, value and opportunities. The implementation of health insurance exchanges (or marketplaces as they are now called) required the sending of new data between exchanges and health insurance carriers to support the implementation of new advance premium tax credits and cost-sharing reductions. Existing transactions had to be modified in a relatively short timeframe. The use of these transactions is mandatory so adoption of the transactions, standards and operating rules (via policies and bulletins published by CMS) by exchange participants is 100%. The barrier or challenge for many issuers has been how to integrate the transactions internally to synchronize their membership and billing systems to reflect the regulatory and business practices of the exchange.

Accurate and timely membership and financial information is critical to the consumer's access to healthcare and all the downstream data exchanges that support the continuum of healthcare service delivery. On the FFM and FF-SHOP, all normalized enrollment and disenrollment activity is done via the 834 transaction. The FF-SHOP currently supports the 820 payment standard and the FFM is scheduled to implement this functionality in January, 2016.

However, the business and data requirements for exchange-related transactions differ substantially from the enrollment requirements for commercial and other lines of business. Other regulatory requirements also require the issuer and exchange to track and reconcile membership and financial data in a way that is substantially different from any requirement for commercial and other lines of business. These differences are based in federal regulations, policy decisions, and process related to exchange operations but the resulting data are conveyed in an 834 or 820 transaction as a result of the Affordable Care Act.

This is in addition to approximately a dozen tactical propriety file formats developed to handle non-standard issues or interim processes. Below is a brief overview of some of the differences between exchange and commercial business that impact the use of the 834 and 820 transactions:

- Exchange coverage includes unique financial components that do not exist for commercial or private coverage, including subsidies (i.e., Advance Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR)) and the FFM User Fee, which must be reflected on enrollment and payment transactions for issuers to incorporate into premium and billing process.
- Issuers normally process 834s/applications from a group, agent, consumer or online portal, which does not involve returning effectuation, cancellation, and termination transactions as in the FFM and FF-SHOP. Generating these transactions requires issuers to store the data from the inbound 834 transaction to return to the FFM or FF-SHOP.

Exchange processes are relatively new and in a state of transition as regulatory, legal and political changes drive the evolution of programs. The full suite of FFM/FF-SHOP enrollment and payment functionality is being continuously developed on a multi-year technology roadmap. As a result, a final, productional and stable set of policy, business and data requirements is not yet available fully assess transaction set improvements and opportunities to increase the efficiency and effectiveness of these data exchanges, and will not be for several more years.

Thus, we recommend that any formal assessment, revisions or recommendations on policies, processes, transactions (with their corresponding standards, code sets or identifiers) not be performed until after completion of an entire enrollment year in which enrollments and payments are supported by a stable set of policies, business and data requirements. During the time period leading up to this assessment, there will be incremental enhancements and deployments that need to be reviewed in total with the overall operation of stable exchange including all related functions (enrollment/disenrollment, payments, reporting, reconciliation, etc.).

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 prior authorization.

Variability of the Enrollment Transaction in State-based Marketplaces

SBMs are not required to implement the same enrollment and payment processes for enrollment as the FFM, thus there is wide variability across SBMs with respect to both the process for sending enrollment information and the content of 834 files. This lack of standardization is a major challenge for issuers that participate in a mix of FFM and SBM states or multiple SBMs, essentially requiring additional IT builds and operational processes for each state in which the issuer offers exchange coverage. For example, SBMs vary widely in their support of the following functions:

- **Implementation of the 834 Transaction** – Each SBM determines which components it will utilize when sending 834 transactions to issuers, including which data elements will be sent for a given scenario and what available codes will be used. For example, on SBM implemented a custom approach to sending reason codes to issuers. Such variability limits the ability of issuers to automate enrollment processes and impacts the timeliness and quality of membership information.

- **Enrollment Process –** SBMs have varying requirements for sending effectuation transactions. While the FFM only requires an effectuation for a new policy upon initial

enrollment, some SBMs require an effectuation for each add, including for existing policies.

- **Membership Reconciliation** – SBMs use varying and inconsistent membership reconciliation processes. SBMs that have a reconciliation process in place (not all do) utilize a model whereby the SBM sends a membership file and the issuer conducts the comparison, which is the reverse of the FFM process. Some SBMs have processes for processing manual changes that deviate significantly from the standard 834 transaction. In addition, SBMs send input files to issuers in different formats and not all data elements are included. Some only send a 'snap shot' of current membership without historical membership information, which leads to enrollment data discrepancies.

- **Approach to Automatic Renewals** – SBMs use different approaches to sending 834 transactions for consumers who are automatically re-enrolled at the start of a new policy year, such as sending a pair of termination and addition transactions versus sending an update to an existing policy.

Use of Enrollment and Payment Transactions in Employer Markets

Health Plan Enrollment/Disenrollment (834)

While nearly half of health plans (58%) who responded to AHIP's survey indicated that the standard meets their needs, 50% indicated that the survey only somewhat meets their needs. Plans indicated that a significant barrier to complete adoption in the employer market is the need for adherence by multiple stakeholders. While the 834 transaction is required of payers, it is not for other stakeholders that are not HIPAA covered entities, namely employer groups. The only way to ensure stakeholders who are not covered entities comply with the HIPAA transaction standard is to require it contractually, which is very difficult to achieve. As a result, because employer groups are not required to adhere with the X12 834 standard for purposes of health plan enrollment, or even to test it, they often implement alternate proprietary solutions instead. Use of alternate formats prohibits further standardization of the 834 and adds continued cost to support proprietary enrollment formats. This transaction standard would be more successful and bring greater efficiency and savings across the industry if it were more broadly required, especially of providers, vendors, and employers.

Health Plan Premium Payment (820)

AHIP's survey similarly indicated that lack of adherence to the X12 820 standard by stakeholders who are not HIPAA covered entities such as providers, vendors, and employer groups limits the success of the standard. Fifty eight percent of health plans that responded indicated that the survey does not meet their business needs or only somewhat meets their business needs. Many respondents indicated that employer groups request alternate formats such as flat files that are less complicated than the standard. One respondent indicated that while the HIX 820 standard is used by CMS for payments in the Federally-facilitated Small Business Health Options Program (FF-SHOP) and intends to implement the 820 for payments related to individual enrollments in the Federally-facilitated Marketplace (FFM) in 2016, the business

model for the X12 820 standard is limited due to this use of proprietary approaches by other stakeholders. Respondents indicated the transaction would be more successful and more broadly used if it was required for stakeholders such as providers, vendors, and employer groups.

Closing

We understand that the Review Committee is particularly interested in understanding and evaluating the use of the enrollment/disenrollment and premium payment transactions in exchanges. Because use of these transactions is a central component to exchange participation, ensuring that they function effectively and efficiently will be a key consideration in ensuring the ongoing stability of exchanges. However, exchanges, and the use of these transactions for exchange-related enrollments and payments, are still in their infancy and it would be premature to make any determination of their effectiveness or begin making changes to the transaction standard. Issuers and exchanges are still working hand in hand to implement policies and business processes to support these transactions; thus the Review Committee should not evaluate or make a determination of their effectiveness until exchanges have stabilized.

AHIP and its member health plans are willing to continue providing feedback to the Committee on the use of these transactions and provide insight into their effectiveness at that time.

We appreciate the opportunity to provide this testimony to the Committee.