Written Statement of Merri-Lee Stine
On behalf of Aetna and America's Health Insurance Plans
to the
ACA Review Committee
Regarding Health Plan Eligibility, Benefits Inquiry & Response
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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 ability of the currently adopted standards and operating rules to meet the current and near term needs of the industry, specifically from the perspective of a health plan.

The standard EDI eligibility transaction implementation standard provides a rich transaction that has the ability to describe many types of plans and their associated benefits.

The development of CAQH CORE's Phase I and Phase II Operating Rules, which added specific requirements around data content for this transaction has brought the industry closer to consistency in support across the payer community.

Unfortunately, there are gaps where it comes to the ability to communicate the types and complexities of today's health plans. The existing eligibility transaction was written years before many of the current products in use by health plans were conceived, developed and sold.

Some examples of the limitations we see are:

- Communication of the order of member financial responsibility

- Multi-tiered benefit plans:
- Plans with multiple levels of in-network benefits
- Federal and State Exchange benefit information, including delinquency premium payment grace period details- which are important to providers
- Other complex plan designs that were created in the years since the guides were written

We recognize that some of these issues are in the process of being corrected by X12 through the development of the next version of the 270/271 transaction. There are changes to the standard and code sets that are needed to address these limitations in the currently adopted transaction. Exchange versions of various transactions have been or are being developed but are not adopted under administrative simplification rules.

One of the enhancements to the next version of the guide will include externalization of the codes used to define the benefits being requested, the Service Type Codes. This change will be a big step forward for the industry in keeping up with the fast-paced changes in the benefit offerings as the list has become stale and does not represent the service breakdowns that are offered today. An example of a service that is not currently available but is on the forefront of industry development is related to Telemedicine benefits. Payers and their plan sponsors have begun to offer benefits for Telemedicine visits, but as this is still an emerging technology for many plans and providers, and the providers are unsure whether the service is covered. The current transaction does not provide a mechanism for them to ask the question "Does this member have coverage for Telemedicine?" The planned externalization of the Service Type Codes will allow for a flexible list of codes, managed outside the implementation guide process that will be updated three times a year.

Another change we look forward to in the next standard implementation is also a code list that has been separated from the standard itself. The codes that describe the type of plan in which the member is enrolled is another example of a list that was timely and pertinent at the time of creation, but has been recognized by the industry to have become stale in the years since. The separation of the code list will allow for more frequent updates and codes that more accurately describe the plans themselves.

Once these and other changes are made to the standard, Operating Rule changes must also be considered. The last phase of Operating Rule development for the eligibility transaction was based on version 4010 and updated for the mandated upgrade to version 5010.

While there are many more changes that the industry requires and can expect, the important point is that industry move forward. The guides and associated Operating Rules must move forward at a pace that allows the information within the transaction to be communicated in an efficient and codified manner.

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 Health Plan Eligibility, Benefit Inquiry, and Response transaction is below.

While health plans that responded to AHIP's survey generally indicated that the 270/271 transaction is meeting their current business needs (56%), they also noted that there is opportunity for improvement. Specifically, health plans referenced variations in benefit designs and complex product designs as a barrier to implementation because they cannot be easily communicated through the existing transaction standard (e.g., tiered copayments for a service based on a broad category of provider specialties). Plans also responded that providers are seeking more specific data (e.g., by service and location) and that many plan systems cannot currently support that level of specificity in the 271 response.

Closing

Ultimately, the standard transaction and the associated Operating Rules have brought the industry together, but we need to continue to move forward. Predictable, flexible updates to the standards that are able to react to the changes in the products, network arrangements and plans that are offered are key.

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