Electronic Funds Transfer and Electronic Remittance Advice

Peter Walker

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Background and History

Electronic Funds Transfer

Generically, electronic funds transfer (EFT) is the electronic exchange or transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems.

The term can be used to cover a number of different concepts:

- Credit or Debit Card transactions
- Direct deposit payroll payments
- Payments consumers authorize be taken from their account
- Electronic bill payment via online banking
- Wire transfer via an international banking network (carries a higher fee in North America)

(based on Wikipedia http://en.wikipedia.org/wiki/Electronic_funds_transfer**)**

Electronic Funds Transfer

In discussions regarding health care transactions, the term EFT usually has a more limited meaning, which is now part of a definition in HIPAA regulations.

". . . a health care claims payment using an electronic funds transfer (EFT) through the ACH Network."

(underlining added for emphasis)

(http://www.gpo.gov/fdsys/pkg/FR-2012-01-10/pdf/2012-132.pdf page 34 adds a definition of "Stage 1 payment initiation" (which includes this wording) to 45 CFR 162.103)

EFT Standard

The health care industry and its banking partners have historically used the Automated Clearing House (ACH) process for transferring funds electronically.

This is a low cost “batch” process widely used in the US to transfer funds between bank accounts.

NACHA is the organization that publishes the standards for data files used to initiate ACH transfers and communicate information on them between banks.

Other funds transfer services in use in the USA but not widely adopted for health care claims payment are Fedwire and the credit/debit card transaction networks.

These services transfer funds in “real-time” but have higher transaction fees.

Electronic Remittance Advice

An electronic explanation sent to a health provider of a health care claim payment or an explanation of why there is no payment for the claim. It is a standardized electronic equivalent of a paper EoB (Explanation of Benefits).

The ERA is sent from a health plan's claims processing system and processed into the provider's billing and collection system.

Unlike the EFT, the ERA includes detailed, personally identifiable, health information.

Use of the ERA has significant cost savings for providers.

ERA Standard

The original HIPAA transaction regulations required the use of the version 4010 “835” standard, as defined in an implementation guide and associated standards publications from the ASC X12 organization.

This requirement has now been updated to the version 5010 “835” standard.

This standard has to be used when remittance information is sent electronically from a health plan to a provider and a health plan has to provide the information electronically if requested by the provider.

ERA Explanation Codes

In the ERA, the explanation for payments that differ from the billed charges is communicated using standard codes.

When correctly and consistently used, these standard codes enable providers to automate:

- allocating payments appropriately
- adjusting accounts for amounts they cannot collect (due to contractual or regulatory requirements).
- billing of charges to patients/responsible parties
- sending claims to secondary payers

ERA relationship to EFT

The ERA is used to “post” payment to, and make adjustments to, the accounts of the patients included in the claims on which the ERA is reporting.

Providers need to ensure that the payments posted to patient accounts match with the payments received.

Historically, a paper EOB had a paper check attached. The remittance advice and payment therefore “travelled together”.

The HIPAA transaction standards require health plans to send the remittance information electronically (when requested by the provider), but did not mandate standards for electronic payment.

ERA relationship to EFT

The ERA does not support transmitting payment, so payments “travel separately” and providers need a process for matching ERA information to payment information.

The ASC X12 standards documents have included instructions on how to send the data needed for this reassociation, but these have not always been consistently interpreted, adopted or supported.

ERA relationship to EFT

The items of data needed for reassociation are:

1. The amount of the payment
2. An identifier for the payer
3. An unique identifier for the payment

All three items need to be consistent between the ERA and EFT and available to the reconciliation process.

When a paper check is used, the check carries the payment amount, the name of the payer, and a check number.

In an EFT, while the payment amount and payer information is always present, the unique payment identifier

- is not always available to the reconciliation process
- is not always provided in the exact format expected by automated reconciliation processes

EFT regulation

A regulation known as an IFC (Interim Final Rule with Comment Period) published in January 2012 defines how healthcare claims payment EFT information has to be sent from payers to their banks when the ACH process is used.

It aligns with the information that is already in the ASC X12 “835” implementation guides and that has been supported by other industry bodies.

Assuming continued use by the industry of ACH to transfer funds, this puts in regulation the framework for passing the information needed to relate an ERA to an EFT.

As of Jan 1st, 2014, payers are required to conform with this regulation when sending payment instructions for healthcare claims payment using ACH.

The full text of the regulation is at
http://www.gpo.gov/fdsys/pkg/FR-2012-01-10/pdf/2012-132.pdf

ERA and EFT usage

ERA and EFT usage has grown significantly since the introduction of the HIPAA ERA transaction standards, but continues to lag behind use of electronic claims.

For 2010, the US Health Care Efficiency Index reports that

- 85% of claims were sent electronically.
- 46% of remittance advices were sent electronically.
- 10% of claims payments were made electronically.

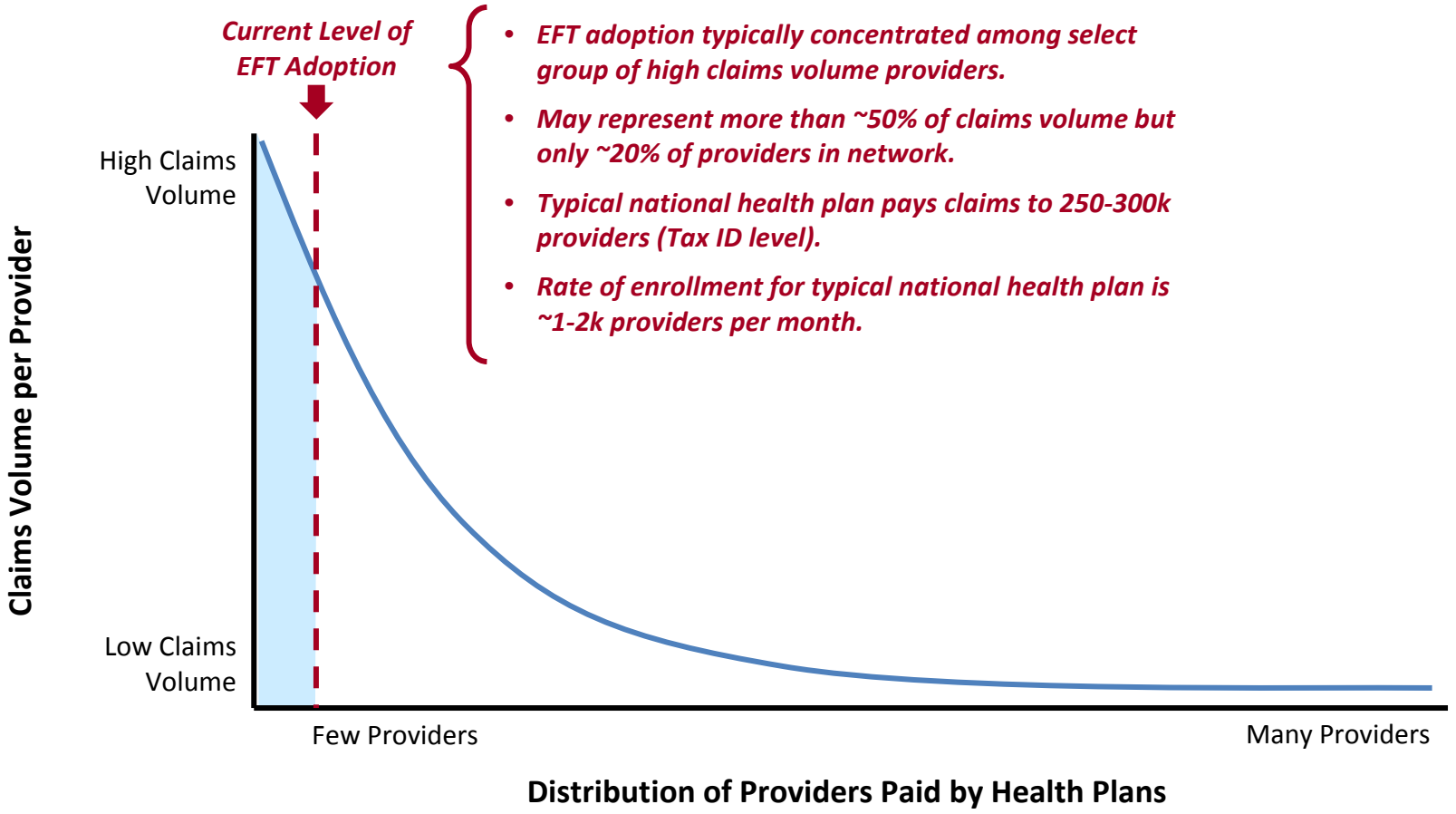
http://www.ushealthcareindex.com/

(Payers who have devoted resources to encouraging provider adoption report higher rates for remittance advice and electronic claims payment, but those rates still lag behind electronic claim submission rates.)

Electronic Funds Transfer Adoption

Variation by Claims Volume and Provider Size

(from CAQH CORE research)

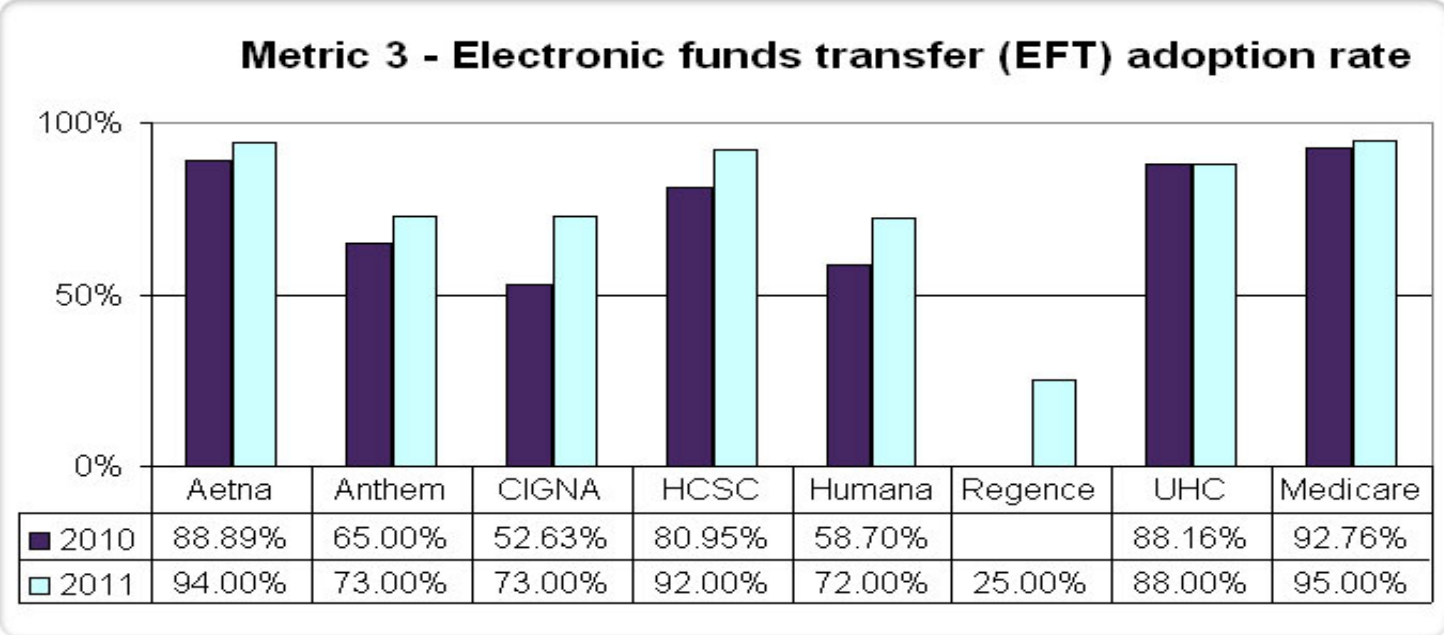


- ***EFT adoption typically concentrated among select group of high claims volume providers.***
- ***May represent more than ~50% of claims volume but only ~20% of providers in network.***
- ***Typical national health plan pays claims to 250-300k providers (Tax ID level).***
- ***Rate of enrollment for typical national health plan is ~1-2k providers per month.***

Electronic Funds Transfer Adoption

Variation by Payer

AMA's National Health Insurer Report Card (NHIRC), which is based on claims data provided by groups that have adopted best practices for electronic data interchange and contract compliance, shows a higher level of adoption than USHIE and increases in EFT adoption for major payers from 2010 to 2011.



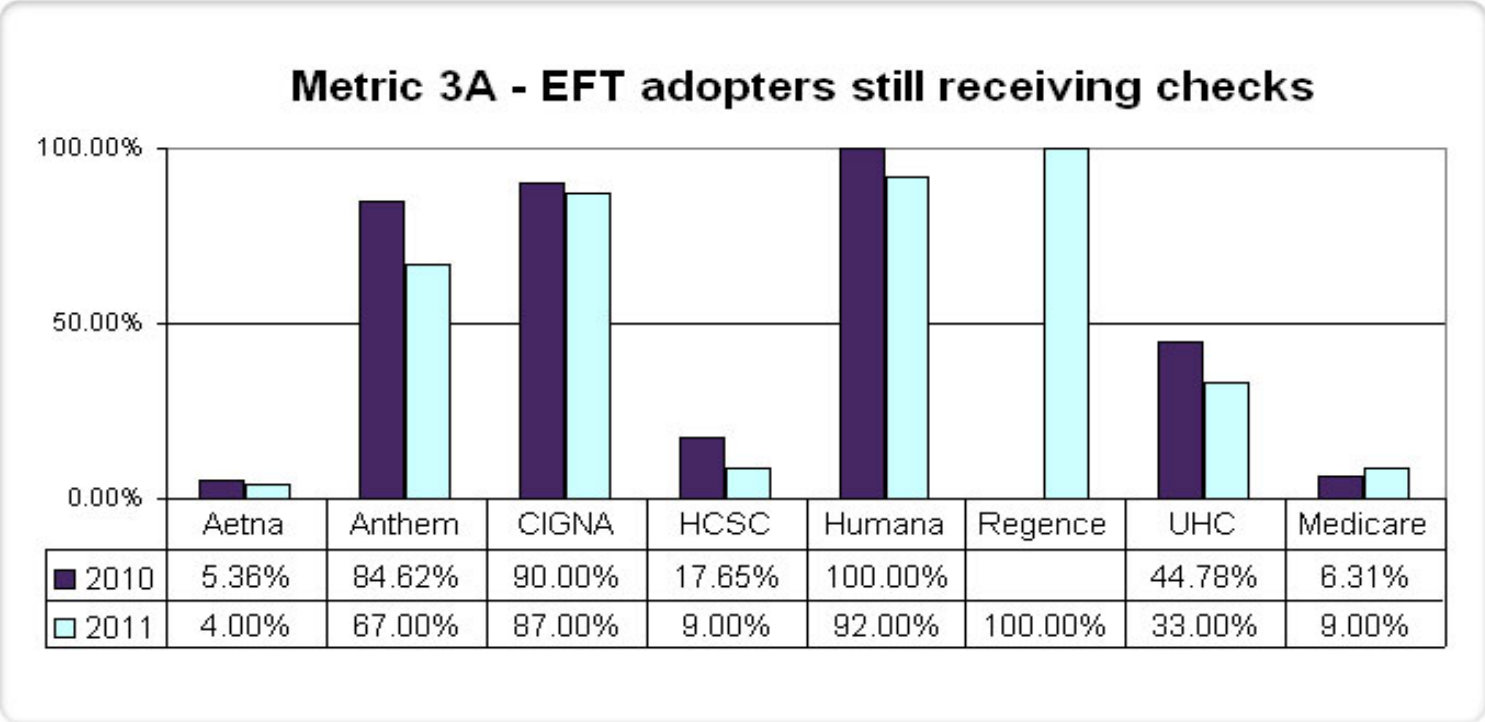
	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
2010	88.89%	65.00%	52.63%	80.95%	58.70%		88.16%	92.76%
2011	94.00%	73.00%	73.00%	92.00%	72.00%	25.00%	88.00%	95.00%

Visit www.ama-assn.org/go/reportcard for more information.

Electronic Funds Transfer Consistency

Variation by Payer

AMA NHIRC data also indicates that some providers who receive EFT payments from a payer have also received payments by check.



	Aetna	Anthem	CIGNA	HCSC	Humana	Regence	UHC	Medicare
2010	5.36%	84.62%	90.00%	17.65%	100.00%		44.78%	6.31%
2011	4.00%	67.00%	87.00%	9.00%	92.00%	100.00%	33.00%	9.00%

Visit www.ama-assn.org/go/reportcard for more information.

Challenges being addressed

Enrollment

The need to meet widely varying health plan enrollment requirements has been identified as a significant barrier to provider adoption of ERA and EFT

This issue is addressed in the draft CAQH CORE operating rules

Explanation of Payment Adjustments

Inconsistent use of the codes used in ERAs to explain payment adjustments has been identified as preventing providers from achieving full benefit from ERA adoption.

This issue is addressed in the draft CAQH CORE operating rules.

This issue has also been addressed by several states (e.g. Minnesota and Washington).

ASC X12 has also produced a technical report proposed to be referenced in a future version of the “835” standards. This is based on work they started to support their application to be named as an operating rules entity.

Reassociation

While the ASC X12N standards documents have included instructions on how to send information for reconciliation, these have not always been consistently interpreted, adopted or supported.

This issue is partially addressed by the IFC for the EFT standard, and is further addressed in the draft CAQH CORE operating rules.

As well as the data needed for reassociation, the CORE rules address the need for ERA and EFT to be sent in the same timeframe.

Federal and State Regulatory Status

Federal Requirements

1) ASC X12 “835” Standard for ERA

(version 5010 required as of 1/2/2012, with enforcement discretion to 6/30/12)

2) NACHA Corporate Credit or Deposit Entry with Addenda Record (CCD+) format (with the standard for the CCD Addenda Record field 3 being the ‘‘TRN Reassociation Trace Number,’’ Segment as defined in the ASC X12 “835” standard.) (required as of 1/1/2014)

http://www.gpo.gov/fdsys/pkg/FR-2012-01-10/pdf/2012-132.pdf

3) Payments by Medicare.

ACA Section 1104 required that all Medicare claims payments use ERA and EFT by 1/1/2014. Medicare already requires that all providers/suppliers enrolling in Medicare or making changes to their enrollment file receive payments via EFT.

Federal Requirements

ACA requires operating rules for ERA and EFT be named in regulation published by July 2012 and required to be in use by 1/1/2014

CAQH CORE in collaboration with NACHA has been recommended by NCHVS as the candidate authoring entity for operating rules for all healthcare EFT and ERA transactions

Recommendations have also been made by NCVHS related to evaluating current processes, creating an expedited path for emergency changes and for testing standards and operating rules before they are mandated.

Federal Requirements

Health Plans have to certify compliance with the ERA and EFT standards and operating rules by 12/31/2013. (ACA Act (Health Care Reform) Section 1104.)

A regulation describing the certification process is expected to be published in 2012.

A proposed rule for a National Health Plan ID is expected to be published soon. This may require use of a new plan identifier in the ERA

State Requirements

A number of states have built on the Federal Requirements with requirements that apply to all payments made to health care providers in their state

For example:

Ohio mandates payment by EFT

Minnesota and Washington have requirements for adjustment code usage

Potential Future Developments

Multi-payer Enrollment

Operating rules that standardize the information collected from providers wishing to enroll in EFT will provide the basis for a multi-payer enrollment service.

Providers will be able to provide information once, and select the payers with whom it should be shared (or not shared).

Simplified Code Maintenance

Understanding the correct way to use and interpret the codes that explain claim adjustments now involves consulting publications from 4 different national bodies and several state level entities.

Getting codes assigned for newly identified situations requires meeting with multiple organizations and takes many months.

Increasing recognition of the problems this creates will lead to a streamlined process.

EFT information to providers

CMS has defined a standard for delivery of EFT information from payers to banks.

They could not define a standard for the delivery of that information from banks to a provider accounting system as they believed no well defined standard currently exists.

NACHA is seeking comments on changes that would require banks to provide the “addenda” information from health care claim payments to providers and competitive pressure will result in more provider accounting systems supporting the use of that information.

Paper will become extinct

Providers who are unable or unwilling to receive remittance advices and payments electronically will

1) have higher administrative costs than providers who have moved to electronic processes.

2) have difficulty being able to contract with or receive assigned payments from health plans due to the cost to plans of maintaining paper processes for a declining number of recipients.

Thank you

Questions?

Peter Walker
Until April 6, 2012 - walkerpt@aetna.com
From April 9, 2012 - peter@walkerhit.com