Healthcare EFTs via ACH

Testimony by Janet O. Estep, President and CEO, NACHA –The Electronic Payments Association
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To the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards

NACHA – The Electronic Payments Association is pleased to submit this testimony to the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards as it reviews the implementation status of the EFT and ERA Standards and Operating Rules. As requested, I will provide an overview and answer the questions provided in advance by the subcommittee.

Status of Healthcare EFT Standards

NACHA manages the development, administration, and governance of the ACH Network, the backbone for the electronic movement of money and data. This subcommittee recommended, and the Secretary of Health and Human Services identified, NACHA's "CCD plus Addenda" transaction as the HIPAA standard transaction for electronic funds transfer (EFT)[1], and named NACHA as the standards organization for the transaction.

In October 2012, NACHA's members approved changes to the CCD+ standard and the NACHA Operating Rules to support the efficient and consistent use of the standard by the healthcare industry. These changes became effective on September 20, 2013, and allow NACHA to identify and track the number of Healthcare EFTs that are transmitted using the ACH Network.

For the month of January 2014 – the first month for which Plans were required to be compliant with the standard – there were a total of 8,154,530 Healthcare EFTs using NACHA's CCD+[2]. These transactions moved 45 billion dollars from payers to payees.[3] Even with no additional growth in the use of the standard for the rest of the year, the ACH Network would move 100 million Healthcare EFTs in 2014, and transfer more than 540 billion dollars from plans to providers.

A second component of the EFT standard is the X12 TRN segment, which is required to be included within the Addenda portion of the CCD+. According to the data we have, 99.93

[1] Federal Register/Vol.77, No. 6/Section II.C. page 1564

[2] As discussed below, at least some CMS payments are not included in this transaction count because the transactions are not using the standardized description by which they are counted.

[3] Appendix A shows monthly Healthcare EFT volume via ACH from Sept. 20, 2013 through January 31, 2014.

percent of the Healthcare EFTs included an addenda record. While we don't have direct insight into whether the TRN segment is being included correctly in all cases, in my view this high percentage is indicative that implementation of that component of the standard has been high.

In addition to actual transaction numbers, we have some additional insight into the number of plans that are using of the EFT standard. ACH Network data show that there were 3,558 unique "company identifications" associated with the volume of Healthcare EFTs. This number represents the maximum possible number of distinct payers using the standard. While the actual number is somewhat lower[4], even half that number represents broad adoption of the standard by the health plans.

Implementation Challenges

NACHA is aware of several implementation challenges with the EFT standard. I will address three here, and include suggestions for addressing each challenge.

1. Compliance with the Standard and the NACHA Operating Rules

From NACHA's perspective, the implementation of the EFT standard appears to have been reasonably smooth. We have been contacted by a small number of financial institutions and processors to discuss and trouble-shoot a small number of processing issues, but these all seem to have been resolved or are being acted upon in good faith to resolve.

NACHA has received reports from financial institutions, however, that some EFTs received from CMS are not formatted according to the EFT standard or the NACHA Operating Rules. An inspection of specific transactions show that CMS is not correctly formatting the TRN Segment in the Addenda portion of the CCD+. This can lead to providers not being able to match an EFT to its associated electronic remittance advice (ERA). Additionally, it appears that CMS is not using the standard description required by the NACHA rules so that a healthcare EFT is easily recognizable by a person reading an account statement.[5] We encourage CMS to verify its compliance with the EFT standard and the NACHA Operating Rules as soon as possible, and we are available to work with CMS on this if it would be helpful.

2. Provider Enrollment for EFT

One of the potential barriers to a provider using the EFT standard is that it must give the plan the banking information necessary so that the EFT is routed to the proper account. This is referred to as "enrollment." In most other instances, enrollment is not a barrier to using EFT. Think of your own cases of getting paid by Direct Deposit – you simply provided appropriate banking information so that your employer can send fund to the correct account.

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[4] Due to various usage and counting issues, the actual number is lower, though by how much cannot be determined from the existing data. Many companies use more than one Company Identification for various internal accounting reasons. Companies will also have at least one unique Company ID for each bank through which they originate transactions.

[5] Examples of these are shown in Appendix C for clarification purposes.

Many providers, however, deal with dozens, if not hundreds, of payers, rather than just a single employer; so the challenge here is one of scale. For example, a provider might enroll in EFT with the 20 percent of the payers from which it receives 80 percent of its funds, but might not devote the resources to enroll with the rest. The CAQH EFT Enrollment Utility is an example of the type of industry utility that can overcome this barrier. The utility enables a provider to enroll for an EFT a single time, and that enrollment is accepted by all plans that use the utility. We commend CAQH for recognizing and addressing this barrier, and recommend that all plans use this utility as soon as possible.

A second potential barrier to enrollment is when plans require providers to submit information that is extraneous to enrollment and unnecessary for EFT processing, and also when the type of information requested varies from plan to plan. Enrollment should be simple, just like getting your Direct Deposit. This is the rationale for the CORE EFT Enrollment Rule. Compliance with the CORE EFT Enrollment Rule will reduce this barrier to enrollment by ensuring that only the information necessary to enroll in EFT is required of providers, and that this information is standardized from plan to plan.

3. Promotion of Virtual Credit Cards and Cost-Shifting to Providers

Providers' use of the EFT standards is also impacted when they are not accurately informed of choice in the method to receive claim payments. In promulgating a final rule, HHS regrettably included the statement that "Health plans are not required to send health care EFT through the ACH Network."[6] Predictably, this has been interpreted by many in the industry (including vendors, processors and clearinghouses) as an explicit opt-out for health plans from supporting the designated HIPAA standard transaction. Many are seeing this as an opportunity to replace checks and EFT standard transactions with "virtual credit card" payments.

In the virtual card process, a health plan issues (likely through its vendor) a single-use credit card number that is mailed or faxed to a provider. This is known as a virtual card because a physical card is never created. The provider is then required to manually key-enter the card number into its Point of Sale (POS) terminal. The provider pays an interchange fee typically around 3 percent of the total amount of the payment.[7] In this process, providers ultimately receive their funds via ACH deposits to their merchant accounts, but pay a high interchange fee for an authorization that provides no additional function or value to the transactions. Vendors are promoting this service to health plans as a way to increase the plans' revenues, as the vendors are rebating a portion of the interchange fee paid by the providers to the health plan. Attached as Appendix B to this testimony is an example of a letter to a plan from a vendor that offers an average rebate of $13.75 per payment; and a second example describing how the virtual card process reduces costs for plans through rebates that are funded by provider-paid interchange fees.

Anecdotally, we have heard of health plans leading providers into accepting virtual card payments through the following methods:

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[6] Federal Register/Vol.77, No. 6/Section II. G.5. page 1567

[7] Chris Wyatt, Director of Product Management, Emdeon at Healthcare Payments Innovation Conference, January 28, 2013 Provider Payments; A Payer's Perspective, slide 9

- "Automatic opt-in" to virtual cards payments, making the provider opt-out if it wants to receive payment by another method, including the HIPAA standard transaction. Some health plans or their vendors are telling providers that want to opt-out of virtual card payments that it takes up to 60 days to reissue the claims payment as either a check or ACH.
- Creating an unnecessarily burdensome EFT enrollment processes to deter use of the EFT standard;
- Raising inaccuracies about the safety of sharing banking information for use in the EFT standard;
- Charging fees to use the EFT standard (i.e., the plan's vendor charging fees to a provider);

Consider the potential impact to a provider of receiving a virtual card payment. As NACHA's data for January 2014 show, the average value of a CCD+ EFT standard transaction was $5,194. When paid by a virtual card, the provider would be charged a typical interchange fee of $155. If all EFT standard transactions in January 2014 were instead made with virtual card payments, the interchange fees paid by providers would have totaled 1.35 billion dollars; annualized for a calendar year would results in interchange fees of 16.2 billion dollars. Even as a replacement for check payments, virtual card payments impose substantial costs on providers – costs that they would not incur by using the EFT standard transaction. If these additional costs are borne by providers, then the expected savings for the industry from administrative simplification will not be reached.

There might be circumstances in which a provider would choose to accept a virtual card payment. We believe, however, that at least in some cases providers are not being afforded the opportunity to freely make choices about how they want to receive claim payments, or may not even be informed as to the options available to them and the costs of each.

NACHA recommends that HHS act immediately to give clear effect to providers' right to use the HIPAA standard transaction for EFT, and that plans be prohibited from disadvantaging those providers that choose to use the HIPAA standard transaction.

Appendix A

Healthcare EFTs via ACH
CCD+Addenda Transaction Volume Identifiable as Healthcare EFTs:

September 20, 2013 – January 31, 2014

	Sep-13*	Oct-13	Nov-13	Dec-13	Jan-14	Total
Total Number of CCD Entries	1,320,762	5,632,451	6,181,681	7,407,418	8,154,530	28,696,842
Total $ Value of CCD Entries	$7,468,915,467	$25,652,623,085	$29,104,874,855	$36,941,667,429	$45,132,009,341	$144,300,090,177

* September 20, 2013 volume covers seven ACH processing days.

Appendix B

Greetings,

Outsourcing your payments processing and migrating your checks to electronic can help your company:

- improve operational efficiencies
- reduce costs
- mitigate risk
- earn rebates

Here is an example of the ROI you can achieve by outsourcing your payments processes and migrating checks to electronic:

- COMPANY A issues 5000 checks per month at a cost of $1.50 is spending $90,000 per year just to pay invoices by check. By migrating 50% of those 5000 checks to ACH at $.50 per payment, a corporation could **save approximately $30,000 per year**.
- Additionally, by migrating just 25% of those 5000 checks with an average check value of $1100 to a virtual card program that has an average rebate of $13.75, COMPANY A can **earn $206,256 per year** from the rebates - turning the finance department into a revenue generator.

Making a decision to outsource shouldn't be taken lightly. However, it is a critical step in moving your organization forward with a sustainable strategy for your payments processes.

I would like to set up a time to discuss your current payments processes and **perform a complimentary ROI Analysis** to determine how we can help you reduce costs and earn rebates.

Book Your Complimentary ROI Analysis Here

Regards,
(name redacted)
VP Sales

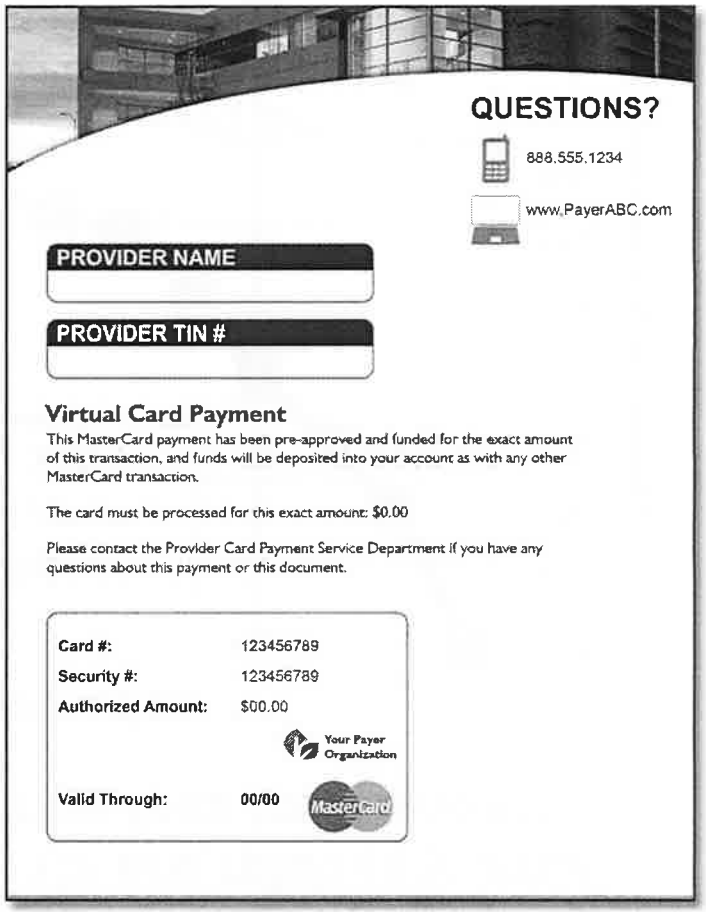
Virtual Card Payments
Bypasses Hurdles of Enrollment, Offsets Costs

Description

- Virtual card payment information is printed and mailed or electronically delivered to providers
- Provider is able to enter transaction into an existing Point-of-Service (POS) terminal which electronically routes the payment using credit card networks and deposits funds into the provider's existing merchant account

Key Benefits

- Converts even more payments from paper to electronic since provider enrollment isn't needed
- Reduces payer print/mail costs as payers are able collect rebates as a percent of credit card transactions
- Does not require provider enrollment (opt out vs. opt in)
- 98% of providers accept credit cards today
- Near zero payer banking fees



Appendix C

Examples of Non-Compliance with Certain CMS Payments

Non-Compliance with Healthcare EFT Standard

The TRN Reassociation Trace Number is not formatted in compliance with the X12 835 version 5010 TR3 Report. The TRN Reassociation Trace Number being used by CMS is formatted with version 4010 requirements; it has not been converted to version 5010 as required.

- The TRN 03 segment in version 4010 was situational and in version 5010 is required. In some situations the TRN 03 segment is missing;
- Version 5010 TRN 03 Company Identifier data segment is a mandatory 10/10 length and the Company Identifier must be start with a "1" followed by the EIN or TIN. When the TRN 03 is used the field length is only 9 characters and the preceding "1" is missing.

Non-Compliance with NACHA Operating Rules

The Company Entry Description Field should be populated with "HCCLAIMPMT" to identify the CCD entries as healthcare claims payments.

- Files from CMS or their vendors do not populate the Company Entry Description field with "HCCLAIMPMT". The field is populated with a variety of terms such as "MED B PMNT" or "DTC DEPOS". If this additional descriptive information is desirable, space is available for it in the Company Discretionary Data field.