Use of Credit Cards – including Virtual Cards – for Claims Payments

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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 use of credit cards – including virtual cards – for claims payments. As requested, I will provide answers to the questions provided in advance by the subcommittee.

Level of use of credit card payments from payers to providers

Over the past 18-months I have had numerous conversations with providers about health plan practices and the use of virtual card payments. In attending conferences and programs I have seen the increase in the number of vendors that offer the virtual card payment process for claims reimbursements and the increase in negative comments and complaints by providers regarding the use of virtual card payments without their prior consent or approval. Providers object to the unilateral imposition of virtual card payments, the shift and the lack of transparency in processing costs borne by providers, and the difficulty of opting-out of the virtual card programs. While many health plans proclaim a high rate of acceptance of the virtual card by providers, this does not mean that providers would voluntarily accept the card if asked. Many providers accept virtual cards only because they have no choice, and due to the extended time it takes to opt out of programs and to receive a replacement payment. At an X12 meeting this winter providers indicated that the time for a replacement payment for virtual card transactions average is between 10 and 60 days, which is a significant impact to the provider's cash flow.

The following are two specific examples:

- On May 13th at the WEDI conference Charlie Myers, Director of Operations, Special Programs and Support for Patient Financial services at Johns Hopkins Health Systems stated that in the prior 6 weeks 13 of their health plan payors had moved from sending checks to virtual card transaction without any request or approval from Johns Hopkins. This resulted in wasted staff

time trying to find a contact at the health plan to request that the virtual card be replaced with a check or ACH transaction and a delay in the processing of payments from those health plans.

- Leann DiDomenico of Performance Pediatrics', a micropractice in Massachusetts, receives virtual cards for small dollar transactions. Her comment was that for small dollar payments it is too much trouble to try to find a contact to request a change. She says, "When I get that virtual card payment in the mail, there's definitely no number to call. If anything, there's a PO Box listed somewhere far from me. So even if I were to write a letter and send it, I would just assume that this company is going to ignore me, this small provider in Massachusetts."

Issues associated with the use of virtual cards in EFT transactions

Lack of transparency –Most health plans do not ask providers before sending virtual card payments. The virtual card numbers are mailed with no information on how to opt-out or the cost to the provider of processing the payment.

Counter to the Goals of Administrative Simplification – The virtual card transactions do not allow for automated reconciliation of the payment and the remittance information. Credit card payments cannot be identified in the HIPAA compliant, version 5010 X12 835 ERA; and a virtual card payment does not include the reassociation number. Providers must manually process the virtual card transaction by key-entering the virtual card number through their office POS terminal, and then manually reconcile the payment to the Explanation of Benefit (EOB).

Increasing the cost of healthcare administration – The use of virtual card payments shifts the costs of payment processing from payors to providers, in some cases by as much as 5% of the transaction value paid in interchange fees. Over the long run, providers would either have to increase the costs of their services, or reduce other costs, in order to cover the costs of this type of payment processing. If these additional costs are ultimately borne by providers, then the expected savings for the industry from administrative simplification will not be achieved.

Impact to the healthcare EFT standard (CCD+Addenda) – NACHA is aware that some providers are being notified that when requesting the delivery of the healthcare EFT standard for claims reimbursement payments that the provider will be charged a percentage of the value of the transaction by the *plan's* vendor. This fee model is based on the interchange fee model for using virtual card transactions.

The following example was taken from the EFT enrollment site for Benefit Management Service:

> For providers enrolling in EFT/ERA: I acknowledge and authorize payments made via ACH based EFT to be subject to a 1.8% provider payment withhold. Further, I acknowledge and agree that said provider payment withhold shall be deemed as a payment from the provider, and shall not be billed to the patient and/or person financially responsible for the patient.

Another provider contacted its financial institution to state that their health plan notified them that there would be a $9.00 charge for every standard healthcare EFT transaction.

Allowing health plans or their vendors to charge the providers to receive standard electronic transactions is not consistent with the administrative simplification goals of the ACA or HIPAA. Providers would be better off receiving checks. This practice also conflicts with the terms of HIPAA 45 CFR 162.925 (5)[1].

Industry Guidance and Education

While CMS has issued FAQ 9778 stating that health plans may not otherwise give providers incentive to use an alternative payment method, or charge excessive fees for delivery of the healthcare EFT standard, "excessive" has not been defined. CMS has also not addressed the unilateral imposition of non-standard electronic transactions.

NACHA is working with CMS, CAQH CORE, the AMA and other healthcare industry organizations to educate the provider on various payment options, the cost of healthcare EFT payment options, and their rights to choose the healthcare EFT standard. Unfortunately there are still a large number of providers that are not aware of their rights to use the standard transaction.

Conclusion

Healthcare providers cannot afford to incur a significant reduction in their practice revenue due to the unilateral imposition of a non-standard payment method that has a one-sided value proposition. Providers should be able to choose to use non-standard payment methods when those methods meet their needs in specific circumstances. Otherwise, providers should be able to rely on the use of the standard transaction.

NACHA recommends that HHS fully treat the EFT standard transaction as it does all other HIPAA standard transactions – as an actual standard, rather than one among many options. In the event that HHS continues to treat the EFT standard transaction as optional, it should establish parameters on when and how a virtual card payments or programs can be implemented:

- Require "Opt-In" for virtual card payments by someone that has authority to make agreements for the provider to;
- Require virtual card payment documents to contain clear instructions on how to "Opt-Out" of the virtual card program if the provider changes their mind on participation
- Require virtual card payment documents to disclose to providers the costs for processing the payment
- Prohibit the requirement that a provider accept virtual card payments as part of their contract with the health plan

These parameters would enable providers to better manage their costs for receiving payments for healthcare claims, and better enable the industry to meet the administrative simplification objectives of the ACA.

[1] 45 CFR 162.925 (5) A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan