



EFT Fees and HIPAA

(June 20, 2014)

Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the fees that health plans can charge physicians and other health care providers who use standard transactions. The specific requirements related to these charges were created from the perspective of electronic claim submission—the most common electronic transaction between health plans and providers—and appear in early HIPAA regulations. With the expansion of HIPAA regulations into electronic funds transfer (EFT), the original statute should now be read to include these new requirements. This document reviews the related regulatory language and applies it to the changed business environment of EFT.

HIPAA - The Law

HIPAA, passed by Congress in August of 1996, amended the Social Security Act in order to improve the efficiency and effectiveness of the nation's health care system. To achieve this goal, the law required the establishment of standardized electronic transactions in health care in order to reduce administrative costs. The law sets forth required actions of health plans, as the Administrative Simplification section 1175 (42 U.S. Code § 1320 d-4) states the following:

(a) Conduct of transactions by plans

(1) In general

If a person desires to conduct a transaction referred to in section 1320d-2 (a)(1) of this title with a health plan as a standard transaction—

- (A) the health plan may not refuse to conduct such transaction as a standard transaction;
- (B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and
- (C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

(2) Satisfaction of requirements

A health plan may satisfy the requirements under paragraph (1) by—

- (A) directly transmitting and receiving standard data elements of health information; or
- (B) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse, and receiving standard data elements through the health care clearinghouse.

Of particular interest to physicians and other health care providers is the clause from 1175 (a) (1) (B), which reads, “the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect...”

Transaction Regulations and Operating Rules

The Department of Health and Human Services (HHS) adopted the first regulation under the law on August 17, 2000. The rule provides the following directives for health plans (bolding added):

45 C.F.R. § 162.925 Additional requirements for health plans.

(a) General rules.

- (1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.
- (2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.
- (3) A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information).
- (4) A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in § 162.923(b).
- (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.**

The 2010 Patient Protection and Affordable Care Act added a new standard transaction requirement—electronic funds transfer—to the original section 1173.

In January 2012, HHS announced an Interim Final Rule that named the NACHA (The Electronic Payments Association) Automated Clearing House (ACH) Cash Concentration and Disbursement plus Addenda (CCD+) format for health care EFT payments by plans as the national standard. The HHS announcement stated, “For physician practices and hospitals, there is little to no cost to implement the health care EFT standards, as providers are the receivers of the standardized transaction and not the senders. Overall, physician practices and hospitals should see savings of \$3 billion to \$4.5 billion over the next ten years as health plans implement the health care EFT standards.” Finalized in April 2013, the rule required all health plans to comply with provider requests to use the ACH Network to conduct EFT and electronic remittance advice (ERA) transactions as of Jan. 1, 2014.

Physicians and other health care providers need to know that health plans may not:

- Delay or reject an EFT or ERA transaction because it is a standard; or
- Charge an excessive fee or otherwise offer providers an incentive to use an alternative payment method to EFT via the ACH Network.

While these regulations require health plans to provide support for the ACH EFT CCD+ format, there is no obligation to support any specific other payment methods. Payers may choose to support payment by check, credit or debit cards, or other EFT formats, but are not obligated to do so.

The EFT Process

In the case of an EFT, the communications flow is different than with other standard transactions. The potential players are:

- Payer – The payer is always involved and is the entity whose bank account is used as the source for the funds.
- Payer DFI – The payer’s depository financial institution (DFI), or bank, is always involved and is the entity that houses the payer’s account and transfers money to the payee.
- ACH – The Automated Clearing House (ACH) is involved when the payer DFI and payee DFI are different institutions and acts as the conduit for the movement of the funds.
- Payee – The payee (i.e., the provider) is always involved and is the entity whose bank account receives the funds.
- Payee DFI – The payee’s depository financial institution, or bank, is always involved and is the entity that houses and accepts money into the payee’s account.
- Payer vendor – The payer vendor, a payment solutions vendor, may optionally be involved and provides value-added services to the payer, which may include initiating payment for the payer with the payer DFI.
- Payee vendor – The payee vendor may optionally be involved and provides value-added services to the payee, which may include matching remittance information with the payments reported by the payee DFI, known as reassociation.

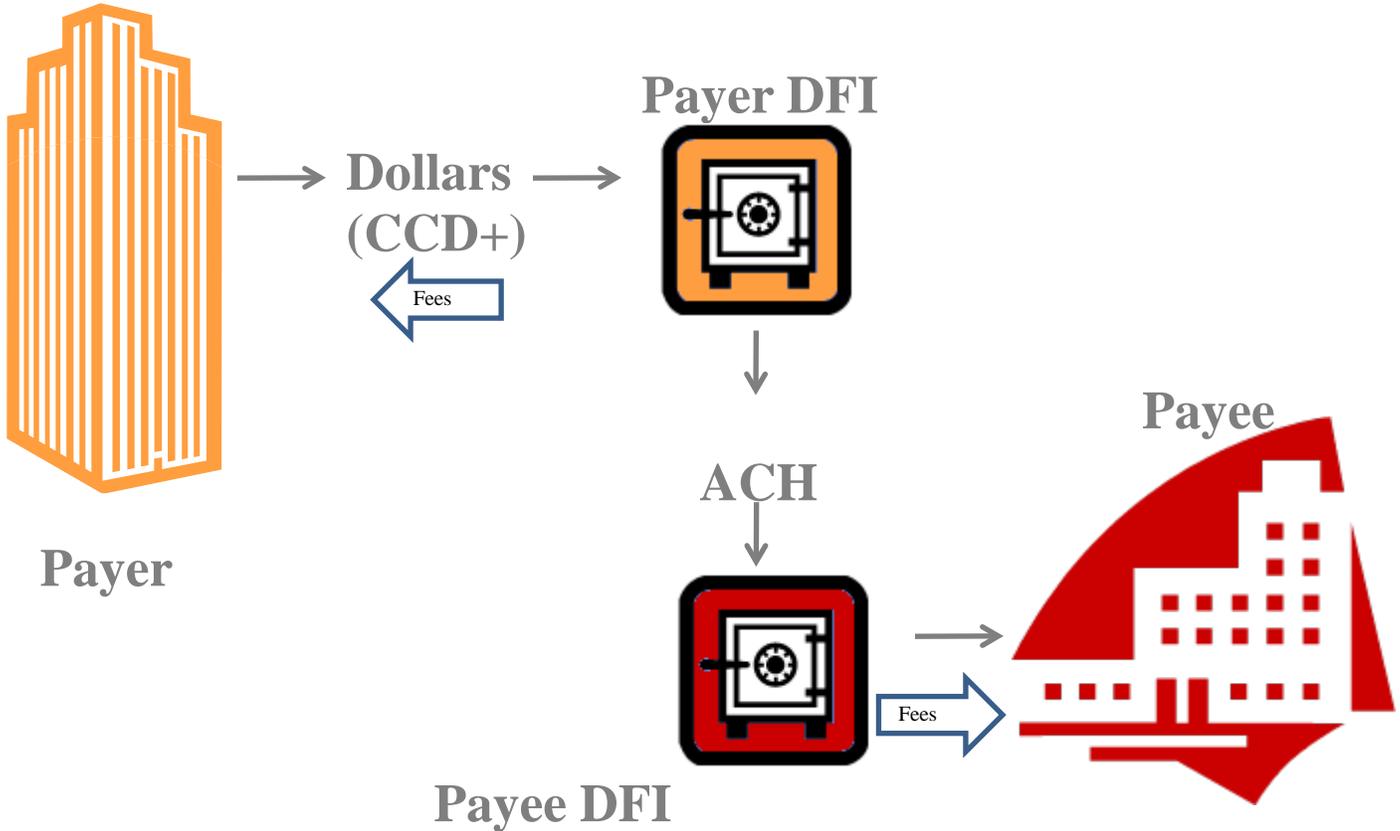
In some instances, the payer vendor and the payee vendor may be the same entity. This only occurs when both the payer and payee contract with that entity for value-added services. **A payee is never obligated to contract with a payer’s payment solutions vendor for any value-added services.**

Note: The payee can work with the payee DFI to ensure that funds only flow into the payee’s account and cannot be withdrawn from the account through payer-initiated debit EFTs. With minimal effort, the payee can be assured that signing up for EFTs can never result in electronic withdrawals by the payer. In addition, the standard electronic remittance advice (Health Care Claim Payment/Advice – Accredited Standards Committee [ASC] X12 835) technical report includes instructions related to overpayment recovery in section 1.10.2.17 that do not include debiting from the provider’s bank account.

Basic Flow – separate DFIs, no vendors

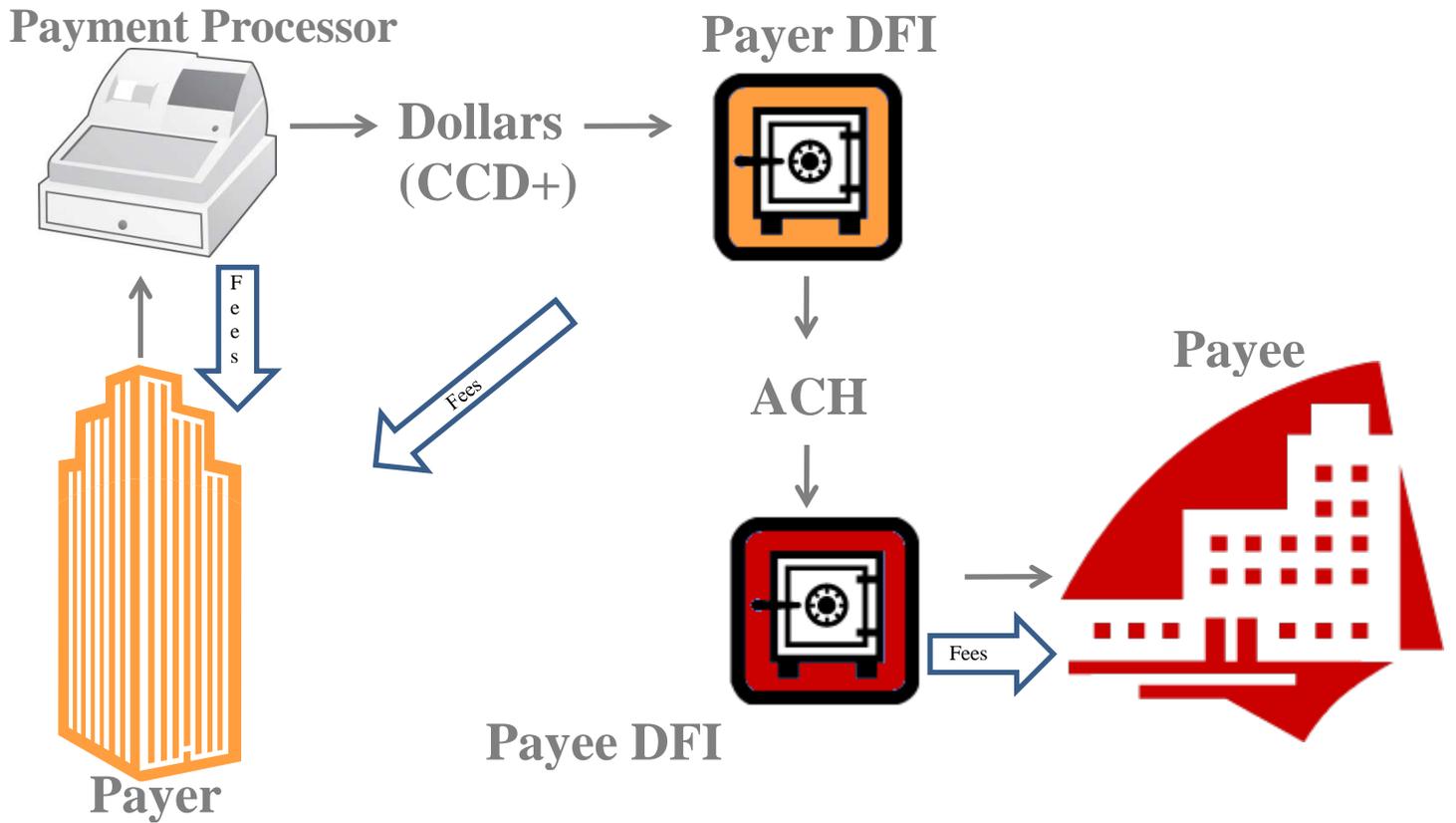
In this scenario, the normal business practice is for the payer to be charged fees by the payer DFI, and the payee to be charged fees by the payee DFI. According to averages quoted by NACHA – The Electronic Payments Association, the payee’s fees are generally about \$0.34 for receipt of the EFT and delivery of the ACH addenda record from the CCD+ to the payee.

Generally, the ASC X12 835 would flow from the payer to the payee separately.



Payer with vendor flow

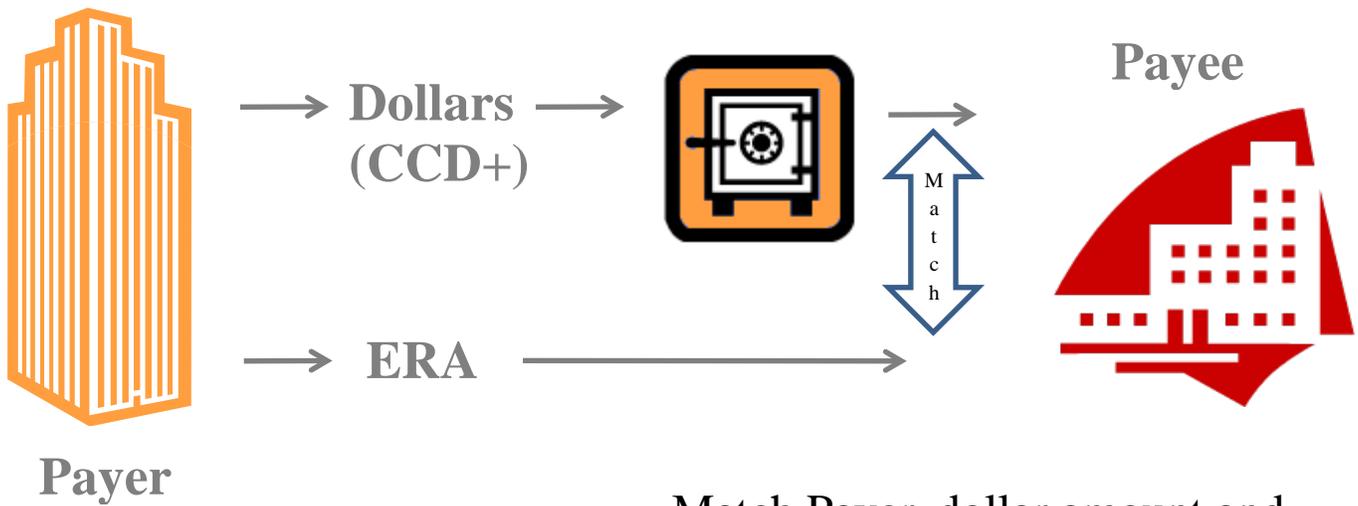
In some instances, a payer may choose to use a payment solutions vendor to do the ACH payment processing for them.



Note: The payment processor is a business associate of the payer. While the vendor may offer value-added services to the payee, there is no obligation to take advantage of those services in order to receive the mandated ACH EFT payments or the related electronic remittance advice (ASC X12 835).

Reassociation

Whenever the money follows one path and the remittance information follows a different path, there is a need to reassociate the two prior to posting payments to the accounts receivable system. Generally speaking, the posting does not happen until the deposit of the payment has been verified. To facilitate this process, the ERA and the EFT both contain the same information in specific locations. Within the ERA and EFT, this is accomplished by matching the payer, the dollar amount and a trace number that must be unique between the payer and payee.



Applicability

The regulatory language indicating that providers cannot be charged fees beyond those incurred “**for normal telecommunications**” was designed for the communications of the standard transactions between physicians and health plans, including claims, remittance information, and eligibility and benefit information. Those transactions stand as separate and distinct business communications that originate at the provider or health plan and are ultimately consumed by the health plan or provider.

In the case of the EFT process, the communication from the payer never goes to the payee. It is consumed by the payer’s DFI and converted into a transfer of funds. The payee receives a communication from their DFI as notification that the transfer has taken place, and that includes a reference identifier that ties the funds to the related remittance advice. On each side, the payer or payee is responsible for the related charges for the services provided by their respective DFIs. The concept of the payer or their business associate (a payment solutions vendor) charging the payee “for normal telecommunications” does not apply.

Because the EFT process involves financial institutions and thus differs from other HIPAA standards, the HIPAA limitation related to costs to providers needs to be applied in a different way. The payee’s DFI already charges fees for communications. Applying direct charges from a payer to the payee for EFT is an additional cost over and above communications costs, and contradicts the HIPAA limitation related to provider costs.

The concept of fees “for normal telecommunications” can apply to delivery of any electronic remittance advice associated with the EFT. The payer, or the payer’s agent, would be transferring the remittance information to the payee, and communications charges for that action can apply under HIPAA.

Intermediaries and Value-Added Services

In some instances, health plans may choose to use a payment solutions vendor to provide ACH EFT to physicians. When this happens, that vendor may attempt to sell value-added services to physicians. Frequently, the service fee of the added value is a percentage of the payment amount. Examples of these fees have been in the range of 1.8 percent to 1.9 percent of the payment. Providers, however, should evaluate these services to determine the real need for these additional costs. Examples of these services may include:

- Reassociation service – A web portal service identifying when the payment has been initiated to the payee’s DFI and associating that service with the related electronic remittance advice (ASC X12 835). While generally physicians may want the confirmation to come from or through their own DFI to identify that payment has indeed been deposited in their account, some may desire to use this type of service. Physicians

should verify what services their existing practice management system vendor and DFI offer to support automation and reassociation before deciding on a portal offering.

- Consolidation of multiple payments from the same or multiple payers – Provision of a single payment related to multiple claims from a single payer or claims from multiple payers. Technically, this requires manipulation of the remittance information, since the ASC X12 835 is explicitly designed to bear a one-to-one relationship with the payment: one ASC X12 835 remittance advice relates to one payment and only one payment. This can also interfere with the capability of the original trace number from the payer to identify the payment. Under this scenario, a new, consolidated payment identifier from the vendor would replace the payer's original trace number. As a result, physicians should exercise care and ensure they are getting the information that they really need to reassociate remittance advice and payment.
- Common ASC X12 835 view – Access to the ASC X12 835 remittance information from multiple payers through a single web portal interface. Ideally a physician's practice management software would receive the ASC X12 835s and post them automatically into the accounts receivable system; however, physicians without this automation may find value in a common interface for viewing of the ASC X12 835 information.
- Prompt payments – Switching the provider to a daily payment schedule instead of existing weekly or other payment cycles. With existing interest rates, any reduction in outstanding accounts receivable due to faster payment must be weighed against the fees for the service.

Whatever value-added services are offered, the important thing to remember is that these are **optional** services that physicians must **choose**. There is no regulatory requirement or mandate that any physician must pay for these options. Every health plan must offer ACH EFT without requiring the purchase of value-added services. Even when a physician desires to receive value-added services, the payer's payment solutions vendor is not the only option. The most efficient processes will maximize the automation within the physician's practice.

All of these services must fit within the context of both the EFT and the ERA for the practice to reduce administrative burden (a very real added cost) and actual costs for the related services.

Summary

Electronic funds transfer as mandated under HIPAA is a cost-effective method for receiving payments from health plans. Many vendors offer value-added services that must be optional and may be duplicated by the physician's existing bank and vendor relationships, with or without the added benefit of automation. Choosing the least costly option that maximizes practice automation is critical to realizing the greatest benefit to the practice's bottom line.