ERIC

The ERISA Industry Committee

July 24, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0026-NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Request for Information – Health Plan Identifier (CMS-0026-NC)

Ladies and Gentlemen:

The ERISA Industry Committee ("ERIC") is pleased to respond to the request for information issued by the Department of Health and Human Services ("HHS") on May 29, 2015, requesting public comments on the requirements applicable to the health plan identifier ("HPID").[1] The HPID requirements appear in Section 1173 of the Social Security Act, first added to the law by Section 262 of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and renewed by Section 1104 of the Affordable Care Act ("ACA"). HHS issued final regulations implementing the HPID requirements on September 5, 2012, requiring controlling health plans to obtain an HPID by November 5, 2014 (November 5, 2015 for small plans) and to use the HPID in standard transactions by November 7, 2016.[2] On October 31, 2014, HHS announced a delay in the enforcement of the final HPID regulations "until further notice."[3]

ERIC'S INTEREST IN THE HPID REQUIREMENTS

The ERISA Industry Committee (ERIC) is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor health, retirement and compensation benefits for millions of employees, retirees and their families.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with a high standard of cost containment and effectiveness.

The health plans maintained by ERIC members are governed by the Employee Retirement Income Security Act ("ERISA"), a complex federal law that regulates nearly every aspect of the plans' operations. ERISA requires certain employers to file annual reports for welfare benefit plans with the Department of Labor, and employers are required to identify their plans by type of welfare benefit (e.g., medical, dental, vision, life, AD&D, long-term disability, etc.) and by plan number (a 3-digit number selected by the employer, starting with 501).

[1] 80 Fed. Reg. 30646 (May 29, 2015).

[2] 77 Fed. Reg. 54664 (September 5, 2012).

[3] See http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

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Under ERISA, employers have significant latitude to determine the number of welfare plans they sponsor. Some plan sponsors may file a single Form 5500 for all welfare benefits (including health and non-health benefits), while other plan sponsors may file multiple Form 5500s for each welfare benefit, or for various combinations of welfare benefits.

The wide range of ERISA reporting variations is clearly illustrated in the DOL's annual report to Congress on self-insured group health plans.[4] The 2015 report shows that, of the 50,239 Form 5500 welfare benefit returns filed for 2012, some 8,319 filings reported health benefits only, while 41,890 filings reported a combination of health and other benefits (this total is further subdivided into various subcategories).[5]

The 2015 report also shows that, of the 50,239 Form 5500 welfare benefit returns filed for 2012, there were 20,551 self-insured plans, 3,983 mixed-insured plans, and 26,675 fully-insured plans.[6] It is important to note that the DOL's annual report data significantly understates the number of employer-sponsored group health plans – plan sponsors are not required to file a Form 5500 for group health plans with fewer than 100 participants, and neither governmental nor church plan sponsors are required to file a Form 5500.[7]

A majority of the health plans maintained by ERIC members are self-insured; the employer hires one or more third-party administrators ("TPAs") to process claims, and the employer remains financially responsible for paying the claims. These administrative arrangements run the gamut: an employer may sponsor a single plan but use multiple TPAs - two or more TPAs handling medical claims (depending on the geographic range of the employer), another TPA handling pharmacy claims, another TPA handling behavioral health and substance abuse claims, other TPAs handling claims for specialized services and/or facilities (e.g., bariatric surgery, cardiovascular surgery and centers of excellence) and still other TPAs handling non-medical claims (e.g., dental and vision claims). Each of these TPAs is separately responsible for conducting HIPAA standard transactions on behalf of the plan, and those obligations are generally embedded in a business associate agreement, not in a trading partner agreement.

In addition, many ERIC members maintain group health plans that combine self-insured and insured elements. These "mixed" arrangements may offer employees a choice of medical benefits – such as a self-insured medical option (such as a PPO) or a fully-insured medical option (such as an HMO). Another common "mixed" arrangement is a group health plan that self-insures some benefits but not others – such as a plan that includes a self-insured medical benefit, a self-insured dental benefit and a fully-insured vision benefit. In some cases, these "mixed" arrangements are offered under a single ERISA group health plan, while in other cases the arrangements may be offered under separate ERISA group health plans.

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[4] The 2015 Report is available here - http://www.dol.gov/ebsa/pdf/ACAReportToCongress2015.pdf.

[5] See Appendix A, Table A1, available here - http://www.dol.gov/ebsa/pdf/ACA-ARC2015.pdf. The plan subcategories include: (1) health and dental; (2) health and vision; (3) health and non-health; (4) health, dental and vision; (5) health, dental and non-health; (6) health, vision and non-health; and (7) health, dental, vision and non-health.

[6] *Id*. For this purpose, a "mixed-insured" plan is a plan that includes both self-insured benefits and fully-insured benefits. We note in passing that the final HPID regulations assumed there were only 12,000 self-insured group health plans. See 77 Fed. Reg. 54664, 54696 (September 5, 2012).

[7] The universe of group health plans sponsored by governmental employers is enormous. The Census Bureau's 2013 Annual Survey of Public Employment and Payroll estimates that there are approximately 90,000 state and local government employers in the United States. See http://www2.census.gov/govs/apes/2013_summary_report.pdf.

Further adding to this complexity is the fact that the design and administration of employer-sponsored health plans change constantly. Employers add, delete or modify their health benefit programs and their TPA service providers frequently, sometimes as often as annually. Corporate transactions add additional complexity: the acquisition of another company or a workplace facility requires the acquiring employer to decide whether to continue operating separate health plans or to merge one health plan with another. In addition, employers frequently maintain separate group health plans for different populations; for example, it is common for employers to maintain separate plans for bargained and non-bargained employees, Medicare-eligible retirees, and expatriates.[8]

The HPID requirements have caused considerable administrative confusion, uncertainty, and consternation for ERIC members. Neither the final HPID regulations nor the CMS enumeration process reflected familiarity with, or accommodation of, employer-sponsored group health plans.

First, the concepts of a controlling health plan ("CHP") and a subhealth plan ("SHP") were completely foreign to ERIC members, and do not reflect terms or terminology used by employers, TPAs, or the other federal agencies regulating group health plans.[9]

Second, there was little or no recognition that HIPAA standard transactions are almost never conducted by self-insured group health plans, and that these plans generally do not have trading partner agreements relating to the exchange of information in electronic transactions.

Third, the enumeration process was clearly not designed for self-insured group health plans – employers sponsoring group health plans had no familiarity with the CMS Enterprise Portal or with HIOS (a system designed exclusively for insurance carriers), and almost every employer encountered procedural and information obstacles to obtaining an HPID, a process involving more than 20 steps[10] . Finally, CMS did not provide answers to some of the most basic questions raised by group health plan sponsors, or specific enumeration guidance for group health plan sponsors, until late September 2014 (in the form of FAQs and "Quick Guides").[11] Even then, CMS proceeded to modify its FAQs and enumeration guidance *again* in October 2014, mere weeks before the November 5, 2014 enumeration deadline.

Major advisory organizations, including the Workgroup for Electronic Data Interchange ("WEDI") and the National Committee on Vital and Health Statistics ("NCVHS"), have been questioning the rationale for, and efficacy of, the HPID requirements for years, particularly as those requirements apply to self-insured group health plans. For example, more than a year before the November 5, 2014 deadline for obtaining an HPID, WEDI recommended that "self-

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[8] The agencies have provided extensive ACA relief for retiree-only and expatriate plans. See ACA Implementation FAQs Part III (http://www.dol.gov/ebsa/pdf/faq-aca3.pdf), Part XIII (http://www.dol.gov/ebsa/pdf/faq-aca13.pdf) and Part XVIII (http://www.dol.gov/ebsa/pdf/faq-aca18.pdf).

[9] The CHP and SHP nomenclature has no precedent. When complying with the HIPAA privacy and security rules, ERIC members have characterized their plans as "hybrid entities" with "health care components" or as "organized health care arrangements" based on long-standing HIPAA regulatory definitions. See 45 CFR §160.103 and 45 CFR §164.103.

[10] See the Quick Reference Guide listing these steps at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPIDQuickGuideSeptember2014.pdf.

[11] More than two years after publication of the final HPID regulations, the FAQs finally clarified some basic questions, one of which was whether fully-insured group health plans were required to obtain an HPID.

insured (group) health plans be permitted but not required to obtain an HPID."[12] WEDI also conducted a survey of stakeholders (including self-insured plans) in August 2014 in which 76% of respondents expressed concerns about HPID implementation, and 85% of respondents thought that there was no value or questionable value in the use of the HPID. (None of the self-insured respondents saw any value in the use of the HPID.)[13] The NCVHS Subcommittee on Standards conducted two hearings on the HPID requirements in February and June 2014, during which nearly all of the industry groups submitting testimony questioned the application of the HPID requirements generally and particularly with respect to self-insured group health plans.[14]

Given this complex and challenging history, we applaud the effort by HHS to reevaluate the need for HPIDs as well as the implementation process itself. Group health plan sponsors and their business associates continue to be confused about why the HPID is necessary, and this confusion continues to exist despite CMS efforts to educate stakeholders. Major issues need to be considered and resolved by CMS before this implementation process can proceed. We are gratified that CMS has decided to "put the brakes on" the implementation of the HPID requirements for the time being, and to seek additional comment from the public. Our recommendations and suggestions are below.

COMMENTS

I. THE HPID REQUIREMENTS ARE NO LONGER NECESSARY AND SHOULD BE ELIMINATED

Section 1104(c)(1) of the ACA requires CMS to "promulgate a final rule establishing a unique health plan identifier that is based on the input of a federal advisory committee, the National Committee on Vital and Health Statistics (NCVHS)." But if the final rule is to be based on NCVHS input, and if NCVHS believes that the HPID requirements will actually disrupt the industry's current use of standard transactions, then little incentive exists for CMS to move forward with implementing the HPID requirements.

The problem, stated bluntly, is that the HPID is a 20-year old solution to a problem that no longer exists. As originally conceived, the HPID was intended to facilitate the routing of standard transactions to appropriate payer recipients. But the industry implemented a standardized national payer identifier based on the National Association of Insurance Commissioners ("NAIC") identifier, and the NAIC identifier is now routinely used to route standard transactions.

Testimony offered at the NCVHS 2014 hearings repeatedly expressed concern that implementing the HPID identifier would interfere with the current flow of standard transactions and introduce significant potential for disruption.[15] The testimony also expressed concern about the lack of

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[12] See WEDI Policy Advisory Group HPID recommendations sent to Secretary Sebelius on October 18, 2013, available here - https://www.wedi.org/docs/publications/wedi-hpid-pag-recommendations.pdf?sfvrsn=0

[13] See WEDI letter describing HPID survey results sent to Secretary Burwell on September 19, 2014, available here - http://www.wedi.org/docs/comment-letters/letter-and-survey-results.pdf?sfvrsn=0

[14] See NCVHS Subcommittee on Standards hearing transcripts here - http://www.ncvhs.hhs.gov/transcripts-minutes/transcript-of-the-february-19-2014-ncvhs-subcommittee-on-standards-hearing/#hpid and here - http://www.ncvhs.hhs.gov/transcripts-minutes/transcript-of-the-june-10-2014-ncvhs-subcommittee-on-standards-hearing/#session6

[15] Id. See, specifically, the testimony of Gail Kocher on behalf of the Blue Cross Blue Shield Association on February 19, 2014, and the testimony of Laurie Darst on behalf of WEDI and Gloria Davis on behalf of

transparency, given that the HPID database would not be public and could not be used to validate information, and the lack of a business justification for using the HPID in standard transactions, given that several standard transactions do not mention when an HPID is required.[16]

In light of the questionable utility of using an HPID to conduct standard transactions, we recommend that CMS immediately halt the implementation of the HPID requirements. We also recommend that CMS immediately clarify that an HPID will not be required for standard transaction purposes or for any other regulatory purpose. (See our additional comments on the ACA certification requirements below.)

II. THE HPID ENUMERATION STRUCTURE DOES NOT WORK FOR EMPLOYER-SPONSORED GROUP HEALTH PLANS

If CMS were to continue to implement the HPID requirements, we offer these further comments on the HPID enumeration structure. The problem for most ERIC members is that the simplistic CHP/SHP enumeration structure does not accommodate the diverse universe of employer-sponsored group health plans. These plans obviously do not "control" their own business activities, actions or policies, but are instead controlled by the plan sponsor. Notwithstanding this central element of control, however, the enumeration process does not assign a single HPID to the plan sponsor. Instead it assigns separate HPIDs to each "CHP" or "CHPs" as self-identified by the plan sponsor.

As noted, the number and variety of "CHPs" offered by a single employer may vary widely, and each "CHP" may have multiple relationships with different TPAs. The regulations do not address these distinctions, and the simplistic examples addressed in the HPID FAQs do not begin to address the complexity that exists in the marketplace. Questions received from ERIC members include the following:

- If an employer offers a "mixed" arrangement, why is it necessary to assign different HPIDs for the self-insured vs. insured options under the plan?
- Why should a plan receive one HPID vs. multiple HPIDs, simply because the employer uses a single plan document (sometimes known as a wrap plan)?
- Does the wrap plan FAQ (which permits one HPID) supersede the insured plan FAQ (which always results in multiple HPIDs)?
- What if a self-insured HRA does not cover "only deductibles" – is it also a CHP that needs an HPID?
- Does the answer vary depending on whether the HRA is or is not integrated with a major medical plan? Or does the answer vary depending on whether the HRA is part of a wrap plan?
- What if an employer offers the same benefits to two different employee groups (e.g., bargained vs. non-bargained) and uses the same TPA to administer claims under both plans – is this one CHP or two CHPs?

The real problem is that employers reading the regulations and the FAQs will, quite rationally, reach different conclusions. Two employers with nearly identical health plan arrangements may

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NextGen Healthcare both on June 10, 2014, all noting that the use of the HPID "will cause disruption of the current well-functioning transaction flows, potentially resulting in payment disruptions and accounts receivable impacts, as well as privacy and security breaches with misrouted transactions."

[16] Id. See, specifically, the testimony of Laurie Darst on behalf of WEDI and the testimony of Laurie Buckhardt on behalf of the Accredited Standards Committee, both on June 10, 2014.

end up requesting one, two, or three, or even more different HPIDs. Giving employers the option of requesting one HPID or multiple HPIDs simply because the benefits are listed in a single "wrap" document guarantees non-uniform results. It is also extremely confusing and frustrating for all concerned. If employers with wrap plans have this option, why shouldn't employers without wrap plans have the same option? All of this leads to a disturbing question – why would CMS create a database of health plans that lacks uniformity and is essentially self-reported? How can such a haphazard, non-standardized approach possibly be reconciled with the agency's stated objective for the HPID, namely to "increase standardization within HIPAA standard transactions and provide a platform for other regulatory and industry initiatives"?[17]

The HPID enumeration approach as it is applied to employer-sponsored group health plans is fundamentally flawed. If CMS intends to continue to implement the HPID requirements for standard transactions or "other regulatory initiatives" we strongly recommend that CMS rethink its approach. There should not be one set of regulatory definitions for purposes of the HIPAA privacy and security rules, and a different set of regulatory definitions for purposes of the HIPAA standard transaction rules (or other regulatory initiatives).

If a database of group health plans is necessary for any reason, then it is incumbent on CMS to develop uniform, standardized enumeration rules for identifying group health plans that are appropriate for these plans and that such rules be consistently applied regardless whether those plans are self-insured, mixed-insured or fully-insured, and regardless whether those plans are sponsored by single employers, multiple employers, unions or trade associations. Moreover, these rules should be consistent with, and follow from, the definitions developed by the Departments of Labor and Treasury when addressing ERISA plans.

III. THE CERTIFICATION RULES SHOULD PROVIDE RELIEF FOR EMPLOYER-SPONSORED GROUP HEALTH PLANS

The RFI does not ask for comments on the proposed certification rules.[18] Nevertheless, the HPID requirements are central to the implementation of those rules, and so these two issues are inextricably intertwined. Moreover, the certification rules suffer from the same inherent problems we have identified for the HPID requirements: namely, a lack of familiarity with, or accommodation of, employer-sponsored group health plans.

We offer the following comments and suggestions.

- The certification rules should not be finalized until further notice. Given the confusion that has surrounded the implementation of the HPID requirements, it would be nothing short of disastrous to move forward with the certification rules at this time. If and when the certification rules are finalized, the new rules should be clearly and timely communicated, and CMS should provide an extended period of interim enforcement relief based on a good faith compliance standard.

- Employer-sponsored group health plans that do not perform standard transactions should be exempt from the certification rules. Instead, plan sponsors should be entitled to rely on certifications obtained by their TPAs (for self-insured plans) or their insurance carriers (for fully-insured plans or the fully-insured components of mixed-insured plans), and CMS should accept a plan sponsor's representation that it has obtained such certifications.

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[17] See 77 Fed. Reg. 54664, 2nd column, "Purpose" (September 5, 2012).

[18] 79 Fed. Reg. 298 (January 2, 2014).

- Employer-sponsored group health plans should not be required to submit covered lives information as part of the certification process. The statute does not require that this data be submitted, and CMS has no need for this data unless and until a penalty determination is made. In addition, the data would be notably untrustworthy given the lack of precision around the CHP definition and employer self-reported HPID enumerations.

- Employer-sponsored group health plans should not be required to certify compliance with the HIPAA privacy and security rules. The statute does not require this certification, and there is an entirely separate, and long-standing, regulatory regime that ensures compliance with those rules and penalizes violations of those rules. The ACA does not require, and CMS should not create, an alternative enforcement scheme for violations of the HIPAA privacy and security rules.

- If certification is nonetheless maintained for employer-sponsored group health plans, CMS should create an administrative corrections process that allows employer-sponsored group health plans, and their TPAs and insurance carriers, to self-correct minor violations of the certification rules. Similar administrative processes have been implemented with great success by other agencies that regulate employer-sponsored plans and offer a means of encouraging compliance and reducing agency resource costs associated with audit activities.

ERIC appreciates the opportunity to provide comments on the RFI. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

Annette Guarisco Fildes
President & CEO