NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0037-P
P.O. Box 8013
Baltimore, Maryland 21244-1850

Submitted electronically at www.regulations.gov

Re: File CMS-0037-P: Administrative Simplification: Certification of Compliance for Health Plans; Proposed Rule

Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to provide comments on the above-referenced Proposed Rule as published in the Federal Register on January 2, 2014 (the "Proposed Rule").[1]

Our comments focus primarily on the proposed requirement that all "controlling health plans," even those that do not directly handle standard transactions, must certify compliance with adopted standards and operating rules for certain standard electronic transactions. We also provide comments on a few other aspects of the Proposed Rule, as described below.

The NCCMP is the only national organization devoted exclusively to protecting the interests of the over 20 million active and retired American workers and their families who rely on multiemployer plans for retirement, health, and other benefits. The NCCMP's purpose is to assure an environment in which multiemployer plans continue their vital role in providing benefits to working men and women. The NCCMP is a nonprofit, non-partisan organization with members, plans, and contributing employers in a broad range of industries, including agriculture, building and construction, bakery and confectionary, entertainment, health care, hospitality, longshore, maritime, mining, retail food, service, steel, and trucking.

[1] 79 Fed. Reg. 298 (January 2, 2014). The comment period was extended to April 3, 2014. 79 Fed. Reg. 12441 (March 5, 2014).

I. SUMMARY OF COMMENTS

- If a multiemployer plan provides health benefits through an insured arrangement, the insurer is the entity responsible for certifying compliance with the standard transactions rules, not the multiemployer plan.
- Self-insured multiemployer plans that have outsourced standard transaction functions should be entitled to rely on certification from their business partners that actually conduct the transactions, and should not be required to file an additional certification of compliance.
- The certification process for standard transactions should not require a blanket attestation of compliance with HIPAA privacy and security requirements.
- The covered life requirement should be eliminated or modified.
- Multiemployer plan sponsors should have an opportunity for corrective action before penalties are imposed.
- The HPID database should not be used for enforcement purposes.

II. BACKGROUND RELATING TO MULTIEMPLOYER PLANS

One of the crowning achievements of collective bargaining between employers and unions over the past fifty years is the creation of thousands of labor-management, multiemployer health and welfare trust funds that provide to covered workers and their families various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. Multiemployer plans provide health and welfare coverage to plan participants and their families according to the terms of conditions of a trust agreement and plan document. Contributing employers are required to contribute to these benefits according to the terms and conditions of a collective bargaining agreement between one or more unions and more than one employer. These agreements typically require participating employers to contribute a negotiated amount per hour worked by covered employees to a multiemployer benefit trust fund administered by an equal number of labor and management trustees. The trust fund, in turn, provides health care coverage for plan participants and their families.

Multiemployer health and welfare funds cover workers in a broad range of industries and were designed to address the needs of employers and workers in those industries. Some of these industries (construction, for example) have mobile, project-based employment patterns that would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers even as they move from employer to employer.

Trustees of multiemployer plans use a wide variety of arrangements to administer their plans. Some plans provide health benefits that are fully insured. Many multiemployer plans are self-insured for some or all of the benefits that they provide, meaning that they do not purchase insurance from an issuer to provide promised coverage. The plan itself bears responsibility for the payment of claims. Self-insured multiemployer plans may retain one or more third-party

administrators (TPAs) to administer the plan or make an "administrative services only" (ASO) arrangement with an insurer for similar services. Plans frequently retain separate pharmacy benefits managers, dental and/or vision providers, or behavioral health management vendors. In short, multiemployer plans use a variety of structures and arrangements to administer their plans and provide coverage, and, under many of these arrangements, some or all of the standard transactions are conducted on behalf of the plan by an entity other than the plan itself.

III. BRIEF SUMMARY OF STATUTORY AND REGULATORY REQUIREMENTS

Section 1173(h)(1)[2] of the Social Security Act requires a health plan to file a statement with the Secretary of the Department of Health and Human Services (HHS), in the form required by the Secretary, certifying that the data and information systems for such plan are in compliance with certain standard transaction rules. These rules include applicable standards and associated operating rules for specified standard transactions: electronic funds transfers (EFT), eligibility for a health plan, health claim status, and health care payment and remittance advice.

Under the Proposed Rule implementing this provision, a health plan that is a "controlling health plan" (CHP) must submit the first certification of compliance (Proposed § 162.926). The first certification covers operating rules associated with the specified standard transactions (eligibility for a health plan, health care claim status, and electronic funds transfer (EFT)/remittance advice). To meet certification requirements, a plan must obtain either of two credentials that will be available from the Council for Affordable Quality Healthcare (CAQC)—either a HIPAA Credential (a new program not yet developed) or a Phase III Core Seal (an existing credential program). Every CHP must submit documentation that it has obtained one or the other to HHS, along with a report of the number of the plan's "covered lives" on the date of the submission.

Although the requirements for these two credentials vary to some extent, both are geared toward entities that actually house data and conduct electronic transactions with trading partners. Both require entities to evaluate their data and information systems for compliance with adopted standards and operating rules, correct any gaps, and to conduct at least some degree of internal and external testing with the plan's trading partners. Both require a senior executive to attest to the plan's compliance with HIPAA security and privacy provisions in addition to the standard transaction rules contemplated by the statute. A CHP that fails to certify as required or knowingly submits inaccurate or incomplete information to HHS or to CAQC risks substantial penalties. (Proposed § 162.612).

A controlling health plan (CHP) is one that "controls its own business activities, actions, or policies" or "is controlled by an entity that is not a health plan," (and that exercises control over any "subhealth plans" it may have). (Proposed § 162.604, incorporating the definition of CHP from the final health plan identifier (HPID) rule, 42 CFR §162.103). The term "health plan," under the regulatory definition found at 45 CFR § 160.103, encompasses nearly every type of plan that covers or pays for the cost of medical care, including group health plans (insured and

[2] Section 1104 of the ACA concerning certifications of compliance added Section 1173(h)(1), 42 USC § 1173(h)(1), to the Social Security Act.

self-insured); multiemployer plans; health insurance issuers; issuers of long-term care policies (except for fixed-indemnity nursing home policies); HMOs; Medicare; Medicaid; federal employee, military, and veteran plans; the Indian Health Service; state child health plans and high-risk pools; and "any other individual or group plan, or combination of individual or group plans, that provides or pays for the costs of medical care." One of the few types of plans excluded from this definition is self-insured, self-administered plans with fewer than 50 participants.

IV. DETAILED COMMENTS ON THE PROPOSED RULE

1. If a multiemployer plan provides health benefits through an insured arrangement, the insurer is the entity responsible for certifying compliance with the standard transactions rules, not the multiemployer plan.

The final rule should expressly provide that a plan sponsor, including the sponsor of a multiemployer plan, that provides coverage by purchasing insurance from a health insurance issuer or HMO is not obligated to comply with certification requirements because the issuer or HMO is taking on that responsibility. Fully-insured plans do not have "data and information systems" within the meaning of Section 1173, and it would make no sense to require their compliance with requirements geared toward entities that actually conduct standard transactions. On the other hand, the issuers and HMOs from which they purchase coverage *do* have data and information systems used to conduct standard transactions, as well as an independent duty as CHPs to certify compliance. The issuer or HMO, not the multiemployer plan that purchases the coverage, should have the exclusive responsibility to certify compliance.

2. Self-insured multiemployer plans that have outsourced standard transaction functions should be entitled to rely on certification from their business partners that actually conduct the transactions, and should not be required to file an additional certification of compliance.

The Proposed Rule appears to impose certification requirements on self-insured plans that have outsourced all standard transaction functions. We believe that this is an unnecessary and burdensome step that would only increase the cost of health care administration, and that may not even be possible to accomplish. It is our understanding from CAQH, the organization that issues the credentials needed to certify, that CORE Seals and the new HIPAA Credential are meant only for entities that actually house data and conduct standard transactions. If this is correct, it may be impossible for self-insured plans that have outsourced standard transactions to meet certification requirements in their current form.

Additionally, the Proposed Rule places certification responsibilities on "controlling health plans." This term was first defined in regulations requiring health plans to obtain a health plan identifier (HPID). That preamble also recognized that "very few" self-insured health plans "conduct standard transactions themselves; rather, they typically contract with TPAs or insurance issuers to administer the plans." Although the HPID rule suggests that self-insured plans may be considered CHPs, it downplayed the significance of any associated obligations, indicating that the impact of the HPID rule on self-insured plans would be minimal. Plans that were not

currently identified in standard transactions (presumably because their transactions are handled by third parties who are themselves identified) would merely have to get an HPID, even though the HPID would not necessarily be put to use.

However, this Proposed Rule appears to expand the requirements considerably for self-insured plans that have outsourced standard transactions. Now any plan that obtains a HPID, including self-insured plans that outsource standard transactions, needs to certify compliance with standard transaction operating rules (no easy task when it does not perform these functions) or face substantial penalties. This proposed requirement is inconsistent with the statutory language found in Section 1173(h) that contemplates certification by plans about their data and information systems.

We believe a better option would be to permit the plans' business associates to obtain HIPAA Credentials, and health plans should be allowed to rely on their business associate's credentials as evidence of their own compliance. We recommend that the regulations permit business associates to obtain HIPAA Credentials from CAQH CORE. In addition, we recommend that a controlling health plan be allowed to rely upon its business associates' HIPAA credentials as evidence of the health plan's own HIPAA compliance regardless of whether or not the business associates conducted tests using that health plan's data.

3. **If self-insured plans that do not handle standard transactions are required to certify, they should be allowed to do so in a simplified fashion.**

If self-insured multiemployer plans that outsource standard transactions are required to certify, they should be afforded a simplified certification method that does not involve fees or a CAQH Credential. Perhaps plans that outsource standard transactions could certify by filing a form indicating that they do not conduct any of the standard transactions covered by the certification. Alternatively, perhaps they could identify the vendors and business associates that conduct standard transactions for them, and to rely upon those entities' representations of compliance with the standards and operating rules

It is our understanding that any entity that conducts standard transactions can obtain a CORE Seal, but that a HIPAA Credential is only available for health plans. Perhaps the HIPAA Credential program under development could be opened up to non-health-plan entities that might be performing standard transactions on behalf of self-insured plans.

4. **The certification process for compliance with standard transaction operating rules should not include attestation as to compliance with HIPAA privacy and security requirements.**

As previously noted, Section 1173(h)(1) of the Social Security Act, added by ACA Section 1104, requires health plans to file a statement certifying that the data and information systems for such plan are in compliance with applicable standards and operating rules for EFT, eligibility for a health plan, health claim status, and health care payment and remittance advice. Section 1173

does *not* require plans to make an expansive certification regarding their across-the-board compliance with all of HIPAA's security and privacy provisions.

The Proposed Rule, on the other hand, requires every CHP to obtain either a HIPAA Credential or a Phase III CORE Seal from CAQH, and to submit proof of this credential. A plan cannot obtain either credential, according to the preamble, unless a "senior level executive" attests that the CHP is compliant with HIPAA's security, privacy, and transaction standards in addition to rules for the transactions covered by the certification. Although this broad certification is apparently an existing requirement of the voluntary CORE Seal program, there does not appear to be any statutory authority for requiring plans to make blanket attestations as to matters not addressed in Section 1173.

5. The covered life report requirement should be eliminated or modified.

The Proposed Rule (§ 162.103) requires health plans to report the number of covered lives as of the date that required documentation is submitted. Covered lives include employees/subscribers as well as spouses and dependents enrolled in or covered by the plan's major medical insurance policies. The stated purpose of the covered life report is to enable HHS to compute penalties. The relevant statutory provision (Section 1173(j)) calls for the Secretary of HHS to compute penalties based on the number of covered lives to be obtained from a corporation's Securities and Exchange Commission filings. In the Proposed Rule, this statutory provision was deemed unworkable, and changed to a requirement that every plan, whether or not it has committed any violation, submit a report of covered lives on the actual day of its certification filing. In our view, HHS is underestimating the burden that this regulation places on plans, and reporting obligations should not be placed on plans that are not in violation of any rules, especially when such a report is not statutorily required. If this report is required in the final rule, it should be limited to plans that have committed a violation.

6. Plans should have an opportunity for corrective action before penalties are assessed

The Proposed Rule appears to contemplate virtually automatic penalties for violations with a limited ability for plans to contest proposed assessments, and no opportunity for corrective action before significant penalties are imposed. We think it is important for penalty provisions to allow plans the time and opportunity to make corrections before a proposed assessment is final.

7. The HPID database should not be used for enforcement purposes.

As explained previously, many multiemployer plans that will be required to obtain a health plan identifier—because they meet the definition of "controlling health plan" contained in the HPID regulation—should nevertheless not be required to submit a certification of compliance with standard transaction rules because they have no electronic data and information systems used to conduct standard transactions and they do not conduct standard transactions. In the preamble to the Proposed Rule, HHS indicates that it plans to use the HPID database to enforce compliance with certification rules. In other words, it will expect each plan that obtains an HPID as a controlling health plan to subsequently submit a certification of compliance by the applicable deadline. As explained above, because it is inappropriate to require every CHP to certify compliance, the HPID database should not be used for this purpose.

Conclusion

We greatly appreciate the opportunity to comment on aspects of the Proposed Rule that may affect multiemployer plans, and are happy to discuss any questions you may have regarding these comments.

Respectfully submitted

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