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Background

The HPID is a standard, unique health plan identifier required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that is intended to provide a standard way to identify health plans in electronic transactions. HHS published a final rule in September 2012 that adopted the use of HPIDs for health plans and set a November 5, 2014, deadline for larger health plans to obtain HPIDs (smaller health plans were given an additional year). The final regulations provided that mandatory HPIDs were to be used to identify health plans, and voluntary Other Entity Identifier (OEIDs) were to be used to identify other entities like TPAs, in HIPAA standard transactions.

The final rule was intended to increase standardization within HIPAA transactions and provide a platform for other regulatory and industry initiatives. HHS stated that it believed the rule would facilitate a higher level of automation for health care provider offices (particularly for provider processing of billing and insurance-related tasks), eligibility responses from health plans, and remittance advice that describes healthcare claim payments. However, healthcare industry participants did not agree. Following publication of the final rule, HHS received substantial pushback from industry stakeholders that claimed the HPID did not satisfy a business need, did not add value, and its implementation would be costly and disruptive. In particular, they claimed the final rule failed to consider the importance of Payer IDs in HIPAA transactions and the impact of accommodating HPIDs rather than Payer IDs.

Accordingly, effective October 31, 2014, HHS announced an indefinite delay to the final rule's enforcement, meaning that HHS will not impose penalties if it determines a covered entity is out of compliance with the HPID or OEID requirements of the 2012 final rule. The enforcement delay applies to all HIPAA-covered entities, including health care providers, health plans, and health care clearinghouses.

Since that time, HHS and the National Committee on Vital and Health Statistics (NCVHS) have continued to gather input from industry participants on the practicality of health plan identifiers. This input culminated in a June 21, 2017, letter from NCVHS to the Secretary of HHS that conveyed the industry's overwhelming preference for Payer IDs over the HPIDs, and recommended that the 2012 final rule requiring health plans to obtain and use HPIDs be rescinded. Testimony gathered from industry participants unanimously supported use of Payer IDs because, while Payer IDs do not identify the health plan, they identify the payers, which is necessary to correctly route HIPAA transactions.

Proposal to Eliminate HPIDs

The proposed rule issued by HHS in December 2018 would eliminate the regulatory requirement for health plans to obtain and use HPIDs, as well as eliminate the voluntary acquisition and use of OEIDs. In support of rescinding the HPID requirements, HHS acknowledged that:

> Industry has developed best practices for use of Payer IDs for purposes of conducting the HIPAA transactions. The adopted HPID does not have a place in these transactions, and from industry's perspective, does not facilitate administrative simplification.
>
> We now better understand the significance of providers being able to identify the payer in a HIPAA transaction. The provider needs to know which organization should receive an inquiry about a patient's eligibility for services, or which entity will receive the health care claim transactions. The organization that needs to be identified in transactions is the payer, rather than the health plan. Industry has clearly communicated that they are successfully routing transactions using the various Payer IDs, and cannot use the HPID.

HHS further acknowledged that the OEID is not useful or necessary, and that other numbers such as the TIN, EIN, or North American Industry

Classification System code from the NAIC can be used successfully in place of the OEID.

The rule also proposes a simplified process for terminating existing identifiers. HHS has indicated that if the proposed regulations are finalized, it will stop issuing HPIDs and OEIDs, deactivate all previously issued HPIDs and OEIDs in the Health Plan and Other Entity Enumeration System (HPOES), and provide email notification to each health plan's or other entity's designated contact person. Health plans and other entities would be free to continue using previously issued HPIDs and OEIDs, but HHS would not regulate any actions entities may take with their identifiers or their use.

What this Means for Employers

There is a 60-day period for the public to submit comments on the proposed rule, which closes on February 19, 2019. After that, we suspect that HHS will issue a final rule that largely reflects the proposed rule. Elimination of the HPID requirement is unsurprising given the immediate and unwavering animosity toward the September 2012 final rule. However, because some form of standard unique identifier for health plans is required by statute, HHS notes in the proposed rule that it will continue to work with industry participants to explore options for a more effective identifier. Accordingly, although HPIDs could be gone for now, a reappearance in some shape or form is inevitable. Employers with self-insured health plans and others involved in HIPAA standard transactions should continue to monitor for developments in this area.

Until then, employers should work with their broker or ERISA counsel to maintain their current HIPAA compliance strategies. Plans that have not yet obtained an HPID can continue to rely on HHS's non-enforcement policy, which will remain in effect during the comment period and until a final rule is published. Plans that have obtained an HPID should wait for the proposed rule to be finalized and utilize any simplified procedures available to terminate their HPID.

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CMS Suspends the Data Match Program

What was the Data Match Program?

Medicare Secondary Payer (MSP) rules determine when Medicare must pay primary or secondary to another coverage provider. Congress enacted the Omnibus Budget Reconciliation Act of 1989 to provide the Centers for Medicare & Medicaid Services (CMS) more robust information about Medicare beneficiaries' group health plan (GHP) coverage, in part, to prevent Medicare from paying primary when it should pay secondary.

The law required the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information about whether Medicare beneficiaries or their spouses were working, and therefore, potentially covered by an employer-sponsored GHP that Medicare should be secondary to under its coordination of benefits requirements. More specifically the SSA would provide the IRS Social Security numbers (SSNs) of Medicare beneficiaries, and the IRS would then match the SSNs to Medicare beneficiaries' tax returns. The IRS would provide this information to CMS, and if CMS determined that the Medicare beneficiary or their spouse may be employed, it would send a Data Match Questionnaire to employers.

Employers were required to respond to these Questionnaires electronically within 30 days or face civil penalties. These Questionnaires asked, among other things, whether the individual was employed, and if so, whether the individual was eligible for an employer-sponsored GHP. As of July 1, 2018, this portion of the MSP rules was suspended. When the Data Match Program was suspended, employers who had outstanding Questionnaires were encouraged to complete the Questionnaire as requested.

What are the current reporting obligations?

CMS still requires mandatory insurer Section 111 reporting for GHPs. Section 111 reporting is also part of the MSP rules. It was designed to help Medicare correctly pay for the health insurance benefits of Medicare beneficiaries by determining whether Medicare should pay primary versus secondary. Section 111 authorizes CMS and a GHP's responsible reporting entity (RRE) to exchange health insurance benefit entitlement information electronically. The insurer or third party

administrator (TPA) will fulfill this reporting requirement for fully-insured GHPs. For self-insured GHPs that are also self-administered, the RRE is the plan administrator or fiduciary. If there is a TPA for a self-insured plan, it is likely that it will be the RRE.

Section 111 reporting requires RREs to submit information electronically on a quarterly basis about employees and dependents who are Medicare beneficiaries with employer-provided GHP coverage that may be primary to Medicare. CMS then provides the RRE with Medicare entitlement and enrollment information for individuals enrolled in the GHP that can be identified as Medicare beneficiaries. This mutual data exchange ensures that claims will be paid by the appropriate organization at first billing instead of Medicare having to request additional payments from the GHP at a later date. The Section 111 GHP reporting process also includes an optional exchange of prescription drug coverage information for Medicare Part D purposes.

Voluntary Data Sharing Arrangements (VDSAs)

Throughout the existence of the Data Sharing Program, CMS has encouraged employers to engage in VSDAs. Even though the Program is suspended, it continues to permit employers to establish these arrangements. VDSAs do not operate that differently from Section 111 reporting, except that it is an employer rather than the insurer reporting this information. If employers establish a VDSA, they must agree to electronically provide the GHPs available Medicare entitlement information to CMS quarterly, and CMS will provide the employer with its Medicare entitlement information for those individuals. Similar to Section 111 reporting, this process is aimed to ensure that Medicare does not pay primary when it does not have to.

There are a number of advantages to establishing a VDSA. Ideally, if this process is accomplished properly, Medicare will not overpay erroneously, and it should prevent errors and delays which could impact Medicare entitled participants and beneficiaries. This is beneficial to employers because CMS has the statutory right to recover amounts that they overpaid. By participating in a VDSA, the employer can avoid repayment demands as well as their negotiations or potential penalties for late or non-payments with CMS.

Whether an employer should sign a VDSA is an important question since it creates obligations for employers that would not otherwise exist. As such, it may be useful for employers contemplating entering into a VDSA to seek legal counsel.

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Narrowing of ACA Contraceptives Mandate Blocked by Federal Court

In 2017, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) issued proposed regulations expanding exceptions to the Affordable Care Act's (ACA's) contraceptives mandate. Specifically, the new regulations expanded opportunities for employers and insurers to invoke religious or moral beliefs to avoid the ACA's requirement that birth control pills and other contraceptives be covered by insurance as part of preventive care. The regulations were finalized in November 2018 and scheduled to take effect January 14, 2019. However, at the final hour, two federal district judges blocked implementation of the new rule.

Background

Under the ACA, non-grandfathered group health plans and insurers are required to provide coverage for specified preventive health services without cost-sharing, including preventive care and screenings for women under guidelines supported by HHS. As part of the ACA's preventive health services requirement, plans and health insurers are generally required to provide coverage for FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.

During the Obama Administration, the Departments issued regulations that provided an exemption for group health plans of religious employers and an accommodation for certain religious nonprofit organizations that did not qualify for the religious exemption. The accommodation was subsequently extended to certain closely held, for-profit entities in the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.* In October 2017, the Departments issued interim regulations further expanding exceptions to the ACA's contraceptives

mandate. The regulations were initiated by an executive order issued by President Trump in May 2017 called "Promoting Free Speech and Religious Liberty," in which he declared that entities with conscience-based objections should be excluded from the ACA mandate.

The new interim regulations (1) expanded the existing exemption under the ACA's contraceptives mandate to make it available to additional employers, insurers, and other entities and individuals that object to contraceptives coverage based on sincerely held religious beliefs; and (2) established a new exemption for certain entities and individuals with sincerely held moral objections to contraceptives coverage. Under the new regulations, a religious or moral exception was now available to nonprofit organizations, for-profit companies (including those that are publicly traded), higher education institutions that arrange for insurance for their students, as well as individuals whose employers are willing to provide health plans consistent with their beliefs. The interim regulations were effective immediately and finalized without significant change in November 2018.

Federal Courts Halt Implementation of the New Rule

Following issuance of the interim regulations in October 2017, the states of California, Delaware, Maryland, New York, and Virginia (later joined by Connecticut, Hawaii, Illinois, Minnesota, North Carolina, Rhode Island, Vermont, Washington, and the District of Columbia) filed a complaint in the Northern District of California to stop enforcement of the interim rules. The states alleged violations of the Administrative Procedure Act (APA) and the Establishment Clause and the Equal Protection Clause of the Constitution. Around the same time, the states of Pennsylvania and New Jersey filed a lawsuit with similar allegations in the Eastern District of Pennsylvania. The plaintiff states in both federal courts subsequently amended their complaints to oppose implementation of the final rules.

On January 13, 2019, the Northern District of California granted a partial preliminary injunction that blocked implementation of the final regulations in the plaintiff states. The Eastern District of Pennsylvania followed suit on January 14, 2019, issuing a preliminary injunction that halted implementation of the final regulations nationwide. Importantly, the scope of the California court's injunction was limited to the plaintiff states after the Ninth Circuit specifically found that a nationwide preliminary injunction was not appropriate. As such, the scope of the Pennsylvania District court's nationwide injunction may be subject to scrutiny by reviewing courts.

What This Means for Employers

The District Courts' decisions delay implementation of the new rules, but the legal proceedings are far from over. Both orders have already been appealed and, regardless of the outcome, we expect that the losing party in both cases will appeal to the Supreme Court. Employers that were hoping to carve out coverage of contraceptives under the expanded rules should consult their ERISA counsel to evaluate related risks until all of the legal proceedings have been resolved. Otherwise, for now, employers and advisors should stay tuned.

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Sixth Circuit Rules Insurance Agents Are Not Employees Under ERISA

On January 29, 2019, the Sixth Circuit handed down a decision that has been highly anticipated among participants in the insurance industry. In the class action lawsuit, insurance agents sued American Family Insurance Company (AFIC) for benefits under the Employee Retirement Income Security Act of 1974 (ERISA). The agents claimed that AFIC misclassified them as independent contractors, while treating them as employees, in order to avoid paying them benefits in compliance with ERISA. In a split 2-1 opinion, the Circuit court held that the agents were properly classified as independent contractors. While the decision relates to insurance agents, it is a good reminder of the rules generally applicable under ERISA to determine proper employee classification.

Background

ERISA defines an "employee" as "any individual employed by an employer." An "employer," in turn, "means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan." Given ERISA's vague definition of employee, the Supreme Court set out a

test in *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318 (1992), for determining who qualifies as a "common law employee" under ERISA. The test uses various factors to determine whether an individual constitutes an employee entitled to ERISA's benefits and protections. Specifically, the Darden factors focus on the hiring party's right to control the manner and means by which the individual's work is accomplished, and include:

- the skill required
- the source of the instrumentalities and tools
- the location of the work
- the duration of the relationship between the parties
- whether the hiring party has the right to assign additional projects to the hired party
- the extent of the hired party's discretion over when and how long to work
- the method of payment
- the hired party's role in hiring and paying assistants
- whether the work is part of the regular business of the hiring party
- whether the hiring party is in business
- the provision of employee benefits
- the tax treatment of the hired party

In 2013, insurance agents performing work for AFIC filed a class action alleging that AFIC misclassified them as independent contractors when they actually should have been classified as employees. The United States District Court for the District of Ohio agreed. The district court ruled that AFIC exerted sufficient control over the agent's day-to-day activities for the agents to be considered employees (e.g., daily activity reports, required participation in after-hours phone solicitations to prospective customers, and some authority to approve or disapprove of the location of the agents' offices and to be involved in the hiring and firing of the agents' staff).

The District Court's holding caused many insurance carriers to re-examine their practices regarding independent agents, and left numerous employers wondering whether *Jammal* was the start of heightened scrutiny of independent contractors under ERISA. AFIC appealed the ruling to the Sixth Circuit.

The Sixth Circuit's Decision

The Sixth Circuit reversed the district court's ruling, finding that the agents were properly classified as independent contractors (*Jammal v. American Family Insurance Co.*, 914 F.3d 449 (6th Cir. 2019)). This is great news for insurance carriers (and employers in similar industries) with independent contractor agents. Particularly noteworthy, the court emphasized that the relative weight given to each factor under the common law employee test depends on the legal context of the determination. This means that the same already factually dependent test may produce disparate results in different contexts (e.g., claims under ERISA versus claims under the Fair Labor Standards Act). This holding also creates a twist in the independent contractor analysis, allowing either side to argue that the factors leaning in their favor should be given more weight than those that are not.

The court noted that control and supervision is less important in an ERISA context, where a court is determining whether an employer has assumed responsibility for a person's pension status. Because ERISA cases focus on the financial benefits that a company should have provided, the financial structure of the parties' relationship carries greater weight than the company's control and supervision of the individual's work. The court stated that the following factors are "especially important" when determining the parties' financial structure: (1) the source of the instrumentalities and tools, (2) the method of payment, (3) the provision of employee benefits, and (4) the worker's tax treatment. Accordingly, the court ruled that these factors should have carried greater weight in the district court's final analysis; and had the court properly weighed those factors in accordance with their significance, it would have determined that the mix of factors favored independent contractor status.

The Sixth Circuit's opinion also emphasized that significant weight should be given to situations where the two parties expressly state their intent to have an independent contractor relationship. In particular, the court found that a written independent contractor agreement executed at the onset of the

parties' relationship provided further evidence that the financial structure of the parties' relationship favors independent contractor status.

What This Means for Employers

Employers with independent contractors should review the financial structure of their relationships in light of the Sixth Circuit's ruling and assess whether individuals are appropriately classified as independent contractors for ERISA purposes. If individuals are misclassified as independent contractors when they should be treated as employees, financial exposure for the employer can be significant. AFIC's estimated exposure exceeded $1 billion.

Employers should also review their ERISA plan documents for "Microsoft language." Microsoft language came out of a lawsuit against Microsoft in the late 1990s where the company was held liable for failing to provide health and retirement benefits to a group of independent contractors who claimed that they should have been classified as common-law employees. In response to this holding, employers since have regularly added language to their plan documents in an effort to avoid a similar result. Microsoft language is often included in the definition of "eligible employee," and excludes from that term individuals who are treated in good faith by the sponsor as independent contractors, regardless of whether they are later reclassified as employees.

Finally, employers should assess their independent contractor documentation. As mentioned, the Sixth Circuit gave substantial weight to the fact that the agents signed written agreements at the outset of their relationship with AFIC stating that they were independent contractors rather than employees. Accordingly, employers should have legal counsel assist with putting these types of agreements in place or, if agreements are already in place, assess the sufficiency of those agreements and consider updating them to ensure that the actual practices of the parties are reflected.

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