AMERICAN ECONOMIC LIBERTIES PROJECT

March 12, 2024

Xavier Becerra
Secretary, Department of Health and Human Services
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Washington, D.C. 20201

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Secretary Becerra and Dr. Tripathi:

We are writing to ask that you undertake a revision of the X12 ASC Electronic Data Interchange file type .837 and .835 standard given the crisis prompted by the Change Healthcare hack and the revealed fragility of our health payments system, and consistent with the White House Executive Order on Promoting Competition in the American Economy, E.O. 14036.[1] As Nikhil Krishnan recently wrote about the consequences of the hack, "Let's be clear about it - the entire issue here is consolidation. Core parts of the US healthcare infrastructure are run by oligopolies at every node that interlock with each other."[2]

One source of the fragility that this hack has revealed is in the standards that the federal government endorses as the only way to transact claims for healthcare services in a legally compliant manner. The way the current standard is implemented, it is difficult to have two functional clearinghouses for a single healthcare provider. Providers must choose one clearinghouse. If a provider must switch, the switching barrier is pointlessly high. In particular, we have heard from multiple parties that payers cannot and will not transmit a .835 Electronic Remittance Advice file to multiple clearinghouses.[3]

Congress created the Office of the National Coordinator for Health IT into the Health Insurance Portability and Accountability Act in 1996. ONC selected the current standard for claims

[1] Executive Order 14036, titled Executive Order on Promoting Competition in the American Economy, July 9, 2021
[2] The Change Healthcare Debacle by Nikhil Krishnan, March 8, 2024, https://www.outofpocket.health/p/the-change-healthcare-debacle
[3] Multiple parties have privately told AELP of this problem. See also The Change Healthcare Debacle by Nikhil Krishnan, March 8, 2024, https://www.outofpocket.health/p/the-change-healthcare-debacle. And Zack Kanter, Founder and CEO of Stedi (https://twitter.com/zackkanter/status/1765170841346531838) See also CMS Statement on Continued Action to Respond to the Cyberattack on Change Healthcare, March 9, 2024 (https://www.cms.gov/newsroom/press-releases/cms-statement-continued-action-respond-cyberattack-change-healthcare) and Letter to Health Care Leaders on Cyberattack on Change Healthcare from HHS Secretary Becerra and Acting Labor Secretary Su, March 10, 2024 (https://www.hhs.gov/about/news/2024/03/10/letter-to-health-care-leaders-on-cyberattack-on-change-healthcare.html)

transmission in 2012.[4] There are numerous use cases for an updated standardized transaction set, but one obvious one is redundancy. Complex systems fail. They crash, they get hacked, they have chokepoints that have myriad issues. The way you solve for this is to build redundancy into the system design - single points of failure will fail eventually, and potentially catastrophically.

Regulators must update these rules mandating that any standards for claims transactions (or any other critical health IT infrastructure) have redundancies and resiliencies built in as the default method of use. These rules should be broad, not just mandate that any given vendor has multiple server banks. The expectation should be that claims transmission can occur through multiple, redundant vendors. Hospitals maintain redundant power supplies, generators, redundant internet connections. It's shocking to learn that the takedown of a claims clearinghouse has brought many, many well-resourced hospitals to their knees, waiting for a vendor changeover at the same time as a metric ton of physicians are scrambling to do the same.

A useful contrast is in the pharmacy system. As soon as Change went down, we understand that most pharmacy operators were able to switch clearinghouses to RelayHealth or PowerLine or another "pharmacy switch" within 48 hours. The reason for this difference is that pharmacies do not use the X12 ASC Electronic Data Interchange file type .837 and .835 standard, they use NCPDP D.0.[5] Thus, pharmacies have been able to transact most claims, with the exception of those claims where Change was also the claims processor. In other words, competition fosters resilience, monopolization facilities dangerous chokepoints.

In terms of claims processing, we would encourage regulators to mandate all systems have at least some level of vendor-level redundancy by default. Redundancy means extra upfront cost, but this cyberattack is halting a large fraction of the entire healthcare payments system. The longer this goes on, the more likely smaller hospitals and smaller practices are to simply fold - they don't have the cash reserves to keep operating as going concerns without any incoming cash.

Should such changes not be viable through regulatory authority, we would encourage Congress needs to pass a bill requiring that the standards for Health IT be designed with redundancy in mind, and devoting money to re-architecting our claims system to expect redundancies at every point possible.

Such new rules and/or legislation would mandate ONC needs to select a new claims standard that doesn't enforce the creation of a single point of failure. If that standard doesn't exist, then X12, HL7, NCPDP and the rest of the standards development organizations need to create one.

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[4] Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions, Federal Register, August 10, 2012 (https://www.federalregister.gov/documents/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers)

[5] 45 CFR part 162, subparts K through R

Sincerely,

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