TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: June 24, 2010

SUGGESTED AUDIENCE: Group Health Plan Responsible Reporting Entities – Question and Answer Session.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Bill Decker
June 24, 2010
12:00 p.m. CT

Operator: Good morning. My name is (Michelle), and I will be your conference operator today. At this time I would like to welcome everyone to the MMSEA 111 GHP Town Hall conference call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question-and-answer session. If you would like to ask a question during this time simply press star and the number one on your telephone keypad. If you would like to withdraw your question please press the pound key.

Mr. Decker, you may begin your conference.

Bill Decker: Thank you very much. Hi, everybody. My name is Bill Decker. I'm with CMS in Baltimore, Maryland. And for the record today is June 24th, 2010. I am here today to host a meeting with you on Group Health Plan Reporting for Section 111. This is a Group Health Plan call, not a non-Group Health Plan call. If you are a non-Group Health Plan RRE or potential RRE this is not your call and you may leave now.

For all of you Group Health Plan RREs out there and potential RREs, welcome. This is the first call we have had since our – obviously, since our previous call, which I think was at the end of March. But there will be another GHP call, Group Health Plan call scheduled, one more later, much later as it turns out. It won't be until September 23rd of this year. That'll be the next regularly scheduled Group Health Plan call.

So between now and September 23rd just keep an eye on the Web site, as things go chugging along. We will have a new GHP User Guide posted on our Web site very early in the month of July. Pat Ambrose, who is also here with us today, will be talking a little bit about that. You will also be hearing

today from Barbara Wright, who is a CMS person, also, and who will be able to talk to us about policy. There are other staff members here. They may chip in from time to time. If they do I will ask them to identify themselves for the record before they speak. And that's what I have for right now.

We're going to open this, as we always do on these calls, with a presentation by Pat Ambrose to go over the recent changes that have been made in the technical requirements and other requirements for Section 111 reporting from GHP plans. I will then talk a little bit about a couple of subjects which I'm sure we're going to get a lot of question on today, one of which is the general subject of HRA reporting.

And after that we will open it up for your questions. If you want to have a question and want to ask a question get yourselves in line. That is put yourself in queue, and when we do open it up, which should be in about 45 minutes or so, you can ask your question. We'll try to answer it for you.

So, right now, Pat, I'm turning it over to you.

Pat Ambrose: OK, thanks, Bill.

First, an announcement about recent postings to the Section 111 Web site. That's at www.cms.gov/MandatoryInsRep. On April 6th, 2010 there was a posting, an alert entitled Revised Collection of Medicare Health Insurance Claim Numbers, or HICNs or HICNs, SSNs, and EINs. This alert is on the overview tab of the Web site, also referred to as the overview page.

Also, on the GHP page, as Bill mentioned, there's an additional upcoming Town Hall teleconference. The schedule and information for that is posted under the GHP Town Hall schedule on the GHP page.

Various updates have been made to the reporting do's and don'ts page so please review those. They will help you with your quarterly file submission. There's an alert on the MMSEA 111 alert page, dated May 28th, 2010. This alert is on HRA reporting.

Also, on the MMSEA 111 alerts page, well, actually, what I wanted to mention is some clarification about some of the pages that have been added to the Web site, so the tabs in that left-hand menu section.

The MMSEA 111 alerts page, which has been out there for awhile, going forward will contain general alerts concerning both GHP and non-GHP Section 111 reporting. A new page has been added, the GHP alerts page. This will be used going forward for GHP specific alerts regarding Section 111 reporting. There's nothing out there yet. Oh, actually, I have a late-breaking announcement, there is a note out there related to the use of Pseudo-TINS, which we'll also talk about today.

And, lastly, you'll see the last option in that left-hand menu is entitled Mandatory Insurer Reporting. This is being used as an archive. When you go to that page you'll see functionality to search through archives, alerts and documents, these are things that have been moved from the regular pages but are still out there for your use.

OK, now, on to changes that are coming in the Version 3.1 of the Section 111 GHP User Guide. As Bill Decker mentioned, we are attempting to get this posted as near to July 1st as possible, so the first expected out the first week of July.

These changes, some of the more significant changes, as always all the changes will be listed in Section 1, but I'm going to cover some of the more significant changes today. Section 7.2.2 was updated to add the following note – each insurer TPA 10 submitted in TL 22 of the MSP input file detail record must have a matching TIN reference file, detailed record, with a TIN indicator of I. This is Field 22 as the insurer, or TPA TIN. Please make sure that for any TIN that you use in Field 22 you're including a TIN reference file record with a TIN indicator of I.

Each employer TIN submitted in TLA 21 of the MSP input file detail records must have a matching TIN reference file of detailed record with a TIN indicator of E, S, F or Z. Failure to submit corresponding TIN reference file

records will result in either errors or compliance flags on any of the corresponding MSP records returned on the response files.

Another update made in the User Guide in Section 7.2.2.2 is a note to say that if you receive a compliance flag for a TIN that you believe to be valid please contact your EDI representative. Your EDI representative has the ability to update the system after they have confirmed with you that there's a valid TIN.

Various sections were updated to note that if an RRE submits both the SSN and HIC number, HICNs, on an MSP input file detail record or the non-MSP input file detail record or a query record the system will use the HICNs only for matching purposes and the SSN will be ignored. We talked about this on the last call, I believe, so again if you submit a record with both an HICN and an SSN the system is only going to try to match the individual to using the HIC number to our database of Medicare beneficiaries.

What else do I want to say? So, again, if no match is found using the HIC number it will not attempt to use the SSN. Now, note that over time a Medicare beneficiary may have different HICN or HIC numbers assigned to them. The system will be able to match to any of those numbers, so even if you're submitting not – if you're not submitting the most current HIC number it still will be able to perform that match.

Notes were added to a couple of sections to state that an RRE does not need to perform the delete add process to update a previously accepted record that was originally submitted with only the SSN after the RRE receives the HIC number on the response file record. Some folks were a little bit confused about the key fields.

In essence, the HIC number and SSN are equivalent in terms of the key fields of records that you're submitting, so even though you might have only submitted the record with the SSN and you get the HIC number back that does not necessitate you performing a delete add of that record to switch over to use the HIC number. And, in fact, as I'll talk about later, we want you to switch over. You are required to switch over to using the HIC number, but on your initial submission it's OK to submit it just with the SSN.

Another, Section 7.2.2.7 was updated to state that RREs are not to submit full file replacement each quarter. You must process your MSP response file per the instructions in the User Guide and you must submit, add, update and delete transactions according to the instructions in the User Guide.

RREs are to continue to submit full file replacements or send the same records over and over again, regardless of the disposition codes returned on the MSP response file are considered noncompliant with Section 111, Mandatory Reporting Requirements, and you most likely will have some follow-up take place regarding that action.

So, again, please adhere to the requirements in the User Guide regarding adds, deletes, and updates. Only send your updates and delete as required. Please do not continue to send the same record over and over again each quarter if that record has already been accepted with an 01 disposition code and you have nothing new to report.

Section 7.2.7 is also being updated to note that MP file submissions will no longer be required as of January 1st, 2011 if an RRE has nothing to report for that particular quarter. MP files will still be accepted but will no longer be required after January 1st, 2011. By MP file I'm referring to a file that's submitted with a valid (hutter) record, no detail records, and a trailer record with a zero record count.

The HRA reporting requirements were updated in Section 7.2.7 to match the alerts that I mentioned previously that has been posted to the Web site. Please note that CMS has removed references to freestanding HRAs. All HRA coverage that otherwise meets the updated requirements is to be recorded regardless of whether the HRA is considered embedded or freestanding. So there's no longer any language in the alerts and subsequently in the updated User Guide regarding embedded or freestanding HRAs, you are simply to report all HRA coverage as long as it needs to be a threshold of a thousand dollars, etcetera.

We also updated the description for the coverage type of R in Appendix A, and for the MSP input file and the MSP response file accordingly so that R

does not – R refers to HRA coverage, period. It does not now refer to only freestanding or HRA coverage that is not embedded.

So let's see, another new requirement, various sections in the User Guide were updated to state that RREs must store the HIC, the HICN, this is Medicare health insurance claim number which uniquely identifies Medicare beneficiaries, you must store the HIC number return on response files in your internal systems, and you are required to use it on future transactions.

The SSN may be committed initially for an individual if the RRE does not have the HIC number either on the MSE input file or a query file. So once a HIC number is returned after matching the individual to a Medicare beneficiary it must be used by the RRE going forward.

A new paragraph was added in the section of the User Guide that discusses SP error codes. This paragraph is entitled Special Consideration for the SP 99 Error. I'll have some more information on that later.

We also added some additional information about how to maintain records returned with a split entitlement indicator of why. This has been discussed on previous Town Hall teleconferences.

Section 7.3 was updated to state that as of January 1st, 2011 your query only input files may only be submitted on a quarterly basis. Only one query only input file may be submitted during a calendar quarter as of January 1st, 2011. This is a change from accepting query files once per month. This change requirement was also noted in other places in the Guide. So please make a note that right now we will accept query files on a monthly basis. So starting January 1st, 2011 we will only accept query files on a quarterly basis, once per calendar quarter.

The descriptions and requirements for the policyholders SSN, field 15, and the individual policy number, field 18, of the MSE input file detail record in Appendix A were updated. Starting July 17th, 2011 RREs must submit either field 15 or field 18. RREs are encouraged to use field 18 instead of field 15, if possible, as has been discussed on previous calls and in various e-mails that have been submitted to CMS field 15 is the policyholder's Social Security

Number, and this field will no longer be required after July 17th. However, you must, if you're not submitting that field 15 you must submit something in field 18.

The value supplied in these fields will be placed on any related recovery demands notifications for the RRE and the employer to use to identify the GHP coverage for the individual reported on that record. So, again, no longer will we require field 15. Right now field 15 is required through July 16 so you have some time to incorporate this change even though that it will be effective in the (COD) Section 111 system on July 17th.

Note that field 18 is the individual policy number. This is the number used or identifier rather used by the insurer or the self-insured employer to identify the individual being reported. Generally it is the number that appears on that individual's insurance card.

OK, so that's the major changes that are being added to the GHP User Guide, Version 3.1. I'm now going to go into some information related specifically to the TIN reference file. Please note that the extension for using Pseudo-TINs or fake TINs for domestic employers has expired.

Again, the extension for using Pseudo-TINs for employer TINs has expired. You must obtain valid TINs for all employer plan sponsors immediately and submit them in field 21 of the MSP input file detail records and submit corresponding TIN reference file records with the proper TIN indicator of (ES4S). The TINs may only be used for foreign employers and those are submitted on the TIN reference file record with a TIN indicator of Z, as in zebra.

If you continue to use Pseudo-TINs for domestic employer or plan sponsors you will get a compliance flag on all associated MSP response file records. We don't want you to stop using or stop submitting the data, so if you are unable to obtain a valid TIN please continue to use the Pseudo-TIN and the TIN indicator of Y if as of yet you have been unable to get the TIN information. But, again, this is not considered compliant with Section 111 reporting requirements and compliance (slights) will be returned.

Also note, as I stated before, that you must submit a TIN reference file record for all TINs submitted in fields 21 and 22 of the MSP input file. This includes both insurer TPA TINs with an I as an indicator and employer plan sponsor TINs with a TIN indicator of E, F, S, or Z. if you do not submit the I record for all insurer TPA TINs in field 22 of your MSP input file record or your I TIN record had errors and was rejected, the MSP records can't be matched to a valid I TIN record and will be rejected with an SP 25 error code. Please contact your EDI representative for help with your TIN reference file and to figure out why TIN records were rejected resulting in the SP 25 and, or compliance flag on your MSP response records.

At a later date in 2011 we plan to provide a new TIN reference file response file, but further details will be announced on that subsequent, and you'll be given plenty of time to react to that so that this response file for the TIN reference file will give you specific information about what might have been wrong with your TIN reference file record. Right now if you're unsure you need to contact your EDI representative.

OK, for more information on that SP 99 error, if you must submit and MSP input file detail record for an individual under age 45 you must submit it with the HIC number. You must submit it with the Medicare health insurance claim number HICN or HIC number. If you submit an MSP input file detailed record for a person under 45 with only the SSN the system will not attempt to match the record to a Medicare beneficiary. It will simply plug the SP 99 error and return it on the response file. This is not in compliance with Section 111 Mandatory Reporting. This means you have either – excuse me, this means you either have to use the query function, the query only input file or basis to obtain the HIC number by querying with the SSN or obtain the HIC number directly from the Medicare beneficiary as it is printed on his or her Medicare insurance card.

Please review the definition of active covered individuals in Section 7.1.2. The SP 99 error is in place to prevent RREs from dumping their entire population of members and dependents without regard to the Section 111 reporting requirements, which only require the reporting of active covered individuals who are Medicare beneficiaries. You are either to use the

definition of active covered individuals and submit those individuals meeting that definition on your MSP input file or query active covered individuals first and submit those found, e-Medicare beneficiaries on the MSP file.

You are not to submit your entire population of covered lives on the MSP file. You are not to query your entire population of covered lives for the purposes of reporting the MSP input file for Section 111 reporting. For that purpose you only need to query those that fit the definition of an active covered individual.

RREs are allowed to use the query function to query individuals that they believe may be entitled to Medicare. For example, retirees, to obtain the Medicare entitlement dates and information about Medicare coverage for those individuals, but there should be no reason to be querying all individuals under age 45, only those that you believe are entitled or possibly entitled to Medicare.

There's more information on abandoned RRE IDs. The COBC is conducting a cleanup project with CMS on RRE IDs that either appear to be abandoned by the RRE or have been in a nonproduction status for an extended period of time.

Associated authorized representative and account managers were sent e-mails and letters regarding this issue. Please follow the instructions in those notifications and immediately contact the COBC EDI Department to either request that the RRE ID be deleted if you're no longer going to use it or moved along in the status progression.

RRE IDs should attain a production status no longer than 180 days after registration has been initiated. If no response is received to these notifications about suspected abandoned RRE IDs, your RRE ID will be put in an inactive status 30 days after that letter was generated.

Another announcement regarding Medicare Advantage, also known as Medicare Part C. This is HMO coverage under Medicare. Do not report Medicare Advantage coverage or Medicare Part C coverage on your Section 111 MSP input file. This is Medicare coverage and CMS and the COBC

already know about this coverage. What we want on that MSP input file is non-Medicare GHP coverage that may be primary to a beneficiary's Medicare coverage.

OK, now I'm going to move down into answering some of the specific questions submitted to the Section 111 mailbox, and I'll ask CMS to chime in as we go along on any of these.

The first one concerns the effective date for reporting HRA coverage. The requirements in the User Guide have led to some confusion, so I'll see if I can try and clear this up. The HRA reporting effective date relates to when the HRA plan year renewed. So, for example, if the plan year starts October 1st then report HRA coverage during your assigned file submission timeframe in the fourth quarter of 2010.

On the other hand, suppose the HRA plan year is July 1 through June 30th. In that case you would send HRA coverage for that the first time in third quarter of 2011 with an effective date of 7-1-2011. So we're not requiring retroactive reporting for HRA coverage, and your initial report depends on when your plan year begins.

So most plan years start January 1st, so most initial HRA reporting will be done in the first quarter of 2011 with an effective date of 1-1-2011. Please note that you cannot report future dated, effective dates. So essentially you're reporting your HRA coverage as soon after the effective date that is later than October 1st, 2010.

And Mr. (Decker) would like to step in here.

Bill Decker: Just quickly, what Pat has just said is entirely correct. We do not require you to send us any information about an effective date that is earlier than October 1st, 2010. We don't expect you to. We don't expect you to send us any information about anyone who is covered by an HRA if their coverage date, the start of the individual's coverage date is before October 1st, 2010.

I want to make it clear that we don't require that reporting. I will also say, however, and this is not to confuse anyone, we won't reject earlier reporting but we don't require it, so you don't have to start until October 1st, 2010.

To add, too, some clarity about why it is we chose October 1st, 2010 as the first date is because HRAs are essentially a product that is managed by rules issued by the Internal Revenue Service, not by anyone else, and as a consequence of that they tend to be year long periods of time, and they tend to be, they tend to run along either a fiscal year or a calendar year report date. That's why we chose October 1st, 2010. If an HRA or potential HRA reporter has effective dates that start after October 1st, 2010 they can certainly report those. If you have a plan year that starts, for example, on say November 1st, 2010 that would be the start of your plan year and you would report anyone who was, who had an effective date after the beginning of your plan year.

Now, that's the important thing to remember here. We got a lot of questions in the interim between our last meeting and this one about that issue, and Pat explained it well, and I hope that what I just said is a little clarification for you there. Remember, the effective date is when the first time you have to begin reporting. You do not, you are not required to report any HRA coverage before October 1st, 2010.

Pat Ambrose: I'm going to add another thing to what Bill said, hopefully not to complicate the issue, but he mentioned a possible effective date for the HRA plan year of November 1st. and suppose that your fourth quarter 2010 assigned file submission period is in October. If that's the case you would end up reporting that HRA coverage initially in your assigned file submission timeframe in January 2011. So it's the first opportunity that you're able to report that information.

Bill Decker: There'll always be a lag between the time you must report and the first opportunity you have to actually report. That's built into the system. It's OK.

Pat Ambrose: OK, another question about HRA reporting related to registration. If an RRE is already registered and has an RRE ID they may use that same RRE ID for their HRA reporting. And obviously you think the coverage type of R to

reflect HRA coverage. And you might be sending two records for an individual, one with the HRA coverage type of R, and another with a coverage type to reflect hospital, medical, drug benefits. Or the regular GHP coverage.

So, again, if you are already registered you may use your current RRE ID to start reporting HRA information. Also, if you are an RRE who has – is reporting HRA coverage for multiple employers or multiple clients you may, of course, report that using your RRE or your insurer TPA TIN as the insurer TIN, and the associated employers as the employer TIN, and all of those can be reported on the same file. So that's, again, an RRE who has multiple HRA plans to report on.

Some other questions came in from an entity that is getting geared up to do HRA reporting, so some of these are kind of going back to the basics of MSP input file reporting, but I thought that I would answer it since we might have a number of people on the call today who are in that same situation and need some clarification.

First, if you have any questions about reporting, Section 111 reporting, how to format the file, what to put in certain fields, please contact your EDI representative via e-mail or telephone to ask technical questions about file formatting and submission.

But, with that said, one of these questions asks about not having the beneficiary sex or gender, and what would happen if they submitted a zero, which is unknown, for the sex or gender code? In the case of submitting zero the system will default the gender or sex to a value of one, which stands for male, in order to perform the matching process to Medicare beneficiaries.

If you do not get a proper sex or gender code for the beneficiary that you're reporting you run the risk of not getting the three out of four match on those fields requirements when the system attempts to match your information to a Medicare beneficiary. So it's OK on occasion to use the default code of zero, but you really need to find a valid sex or gender because you're going to run into trouble with the matching process down the road if you don't have that information.

Another question was asked about the document control number, or DCN. This is a number that is supplied on MSP input file detail records that is, just needs to be unique to each record on the file submitted. It's a number made-up by the RRE, so you could just number it sequentially if you so choose. It is meant as a record identifier to make it easier to locate certain records when problems arise and you're talking about them with your EDI representative. And it also can help the RRE match response records to input file records.

You do not have to maintain the same document control number for a particular record submission from one file to the next. That DCN is only unique within the file being submitted, and you don't have to – you can use a different number each time you send an update record as necessary.

Another question was asked about the transaction type. Please note that you only need to report changes going forward after the initial add record is accepted. If the same coverage continues year to year you may maintain that same record under the original effective date and leave the termination date all zeroes, standing for open-ended. You do need to track the start and end dates of HRA coverage accurately, though. So I think that covers that question.

As far as coverage type for HRA reporting, note that we've updated the definition for the coverage type R and there's no distinction of it being freestanding any longer.

I think we've covered effective dates thoroughly. Again, note that future effective dates cannot be submitted, so submit the record as soon as possible after the appropriate effective date within your assigned file submission timeframe.

If you report coverage that you later find was declined, such that that coverage never existed then you do need to remove that record if it was accepted with an '01 disposition code by sending a delete. So the circumstance here is that the RRE has information at the time they're submitting their MSP input file, that an individual has accepted coverage under an HRA. They later find out that, no, that was incorrect, the individual at the last minute declined the HRA coverage. However, the RRE already reported the HRA coverage and the

coverage was accepted and returned with an 01 disposition code. In that case since the coverage never existed and essentially was erroneously reported, then submit a delete record to remove that erroneous report in your next quarterly file submission.

The policyholder name and other information related to the policyholder should reflect the name of the subscriber or member as it appears on the GHP or HRA insurance card. The beneficiary name fields are to match the individual that you're reporting on the record who is the Medicare beneficiary and is the – and should match what is on the Medicare insurance card.

So there are beneficiary name fields and there are policyholder name fields. You could be two different people for dependent or spouse, for example, who are covered under an employee's coverage. So the beneficiary name is the individual that you are the Medicare beneficiary that you are submitting the coverage record for. The policyholder is essentially the employee and should reflect the name of that individual on the GHP insurance card.

Bill Decker: I'm sorry, go ahead.

Pat Ambrose: This portion I'll pose to Bill. There were several questions related to the rollover amounts from HRA?

Bill Decker: Yes, hi. This is Bill again, Bill Decker. What we say in the alert that's on the Web site now, that has been up there since the end of May, and what we will say in the User Guide when it is published in a couple weeks or so and within a week or so, is this. That you don't have to report any HRA coverage activity to us if the value of the HRA, if the amount of the coverage of the HRA is less than a thousand dollars. Alternatively, you do have to report to us if it is a thousand dollars or more. If the coverage amount of the HRA is $1,000 or more it needs to be reported to us, all other things being in line, that is effective coverage date after October 1st, 2010, etcetera.

If an HRA in the first year it's being reported has a value of, say, $750 and the next year it is – and nothing is spent from it, and then it rolls over into the second year of coverage by the HRA for that Medicare beneficiary. And a new $750 is put into that HRA, the HRA then has to be reported because the

coverage value, the coverage benefit of that HRA is now over a thousand dollars in the coverage period that is in line to be reported.

If the HRA starts out at a thousand dollars or more it has to be reported. If a beneficiary spends money from the HRA that was over a thousand dollars at the beginning and it goes under a thousand dollars it still has to – the activity still has to continue to be reported because they started out at over a thousand dollars.

If an HRA has a benefit level that is under a thousand dollars and it stays under a thousand dollars for the reporting period it does not have to be reported, as I said earlier you can report it but you don't have to.

I do want to point out that any amount in an HRA is considered to be primary to Medicare, and so you need to be clear that that HRA will be spent primary to Medicare spending for the coverage beneficiary even though it is under a thousand dollars. But the benefit level, itself, starts at a thousand dollars for reporting purposes.

For those of you who are HRA people and may not be familiar with why or not familiar anyway with why it's important to us to make sure that we know when we are supposed to be secondary and know when we're supposed to be primary is this. If you report to us that someone has an HRA that is over a thousand dollars, we open up a record on our files that says that Medicare is going to be a secondary payer.

If that is wrong for any reason and the individual who is, you are covering believes that Medicare should be primary and finds out that Medicare is denying claims they may not understand why that is. It's important for you to be very careful about your reporting to us because if you tell us we should be a secondary payer that's what we will believe, and if we are not supposed to be the secondary payer that could be harmful to the beneficiary.

Pat Ambrose: OK, I'm going to move off the topic of HRA and I think Bill might have some additional comments, and certainly we'll take questions later and move into some other general questions.

One, several questions, actually, have been submitted about what do I do if an individual, an active covered individual does not have a Social Security Number? We've been asked this question before, and the answer is if an individual does not have a Social Security Number then they cannot be a Medicare beneficiary and, therefore, do not have to be reported on the Section 111 MSP input file. So for whatever reason, if it's a foreign national, the wife of someone or the spouse of an employee and the spouse is from a different country, doesn't have an SSN, might have GHP coverage, they are not – if they do not have a Social Security Number they cannot be a Medicare beneficiary and, therefore, you do not need to report them.

Let's see, I mentioned earlier about Medicare Advantage Part C. Make sure that you are not reporting Medicare Advantage or Part C coverage as GHP coverage on the Section 111 MSP input file.

A question came in related to that, that then went on to talk about cases of medical malpractice, lawsuits, and possible reporting that might be required for that. And for that I refer you to the non-GHP User Guide that you can find on the NGHP page of the Web site.

And the next question is coming from a third-party administrator, a TPA, self-insured, employer Group Health Plans, and they are set-up as separate trusts. They have the trust EIN, the plan sponsor EIN, the individual employer's EIN, and the basic question, this is not a Taft-Hartley situation but it is a multiple employer plan. And the question was what EIN or TIN do I submit for the employer EIN? In the scenarios provided you want to submit the plan sponsor TIN or EIN in the case of all multiple employer or multi-employer Group Health Plans. That goes in field 21. And then on your TIN reference file record make sure that you include that TIN or EIN with a TIN indicator of F.

Here is another question, where an RRE submitted the GHP MSP input file on March of 2010, the file was missing the TIN numbers for groups for the State of Florida. They noted that this is not a Federal entity, being the State of Florida, but they are asking how to properly report that this is a State entity

and that they don't have the TIN number for them? They've used instead of Pseudo-TIN with a TIN indicator of Y.

Again, as we mentioned earlier, the use of Pseudo-TINs, that extension has expired. Assuming that the State of Florida is the employer plan sponsor of the GHP, which it sounds like in this situation, you must obtain a valid IRS assigned tax identification number for the State of Florida or one of its applicable departments and submit that in field 21 of the MSP input records and submit the TIN reference file record with a TIN indicator of E or employer. The State of Florida would not be considered in this case a multi-insurer, a multi-employer GHP.

Bill Decker: Right. And don't confuse – this is Bill Decker, again – don't confuse the fact that when we sometimes ask for Federal tax ID number, what we're asking for is the tax ID number that is issued by the Federal Government, that is by the IRS. It's not a tax ID number that indicates that somebody is a Federal employer, that might have been some confusion there.

Pat Ambrose: Oh, good point.

OK, another question came in about calculating the employer size and the question was basically do I count the number of employees that are in the particular plan or do I count all the employees? And so note that employer size reflects the number of employees, not just those that are a member of the plan or are in the plan.

So please also in this question on the individual indicated they were a Cobra administrator, and I ask you to review the information in the User Guide on reporting Cobra coverage and references to current employment status in the definition of active covered individuals.

But to answer the real question there, employer size is a count of employees regardless of whether they participate in the GHP or not.

Bill Decker: Fulltime and part-time.

Pat Ambrose: Yes, there's plenty of information about employer size in that User Guide, including a lengthy discussion in Appendix I that has also been updated in the new version of the User Guide to add even further clarity. We're doing the best we can there to explain a rather complicated topic.

A question came in about what do I do if I receive an MSP input file and it indicates the TIN number was invalid or incorrect but the TIN number submitted really was correct? As I've stated before, please contact your EDI representative and they can work with you to have the system updated to recognize that as a valid TIN.

Another question related to employer size, this individual points out that they have reviewed the information in Appendix I on employer size and reporting, the employer size indicator. And they point out that in our examples we're calculating employer size based on the year that the RRE is reporting. We've tried to rectify that and make it more clear that was not the intent.

This individual went on to say that they think you need to base the employer size on the actual effective date of the GHP coverage they are submitting for the member, and that is, in fact, completely accurate. So please note that the employer size is reflective or related to the dates of the GHP coverage that you're reporting and what the employer size indicator was calculated to be at that time.

So if you're reporting coverage in 2009 you certainly need to look at employer size in 2008 and the other related criteria. You need to track employer size and report changes as is shown in examples in Appendix I.

Bill Decker: And, Pat, is there a CBT course in process to address this?

Pat Ambrose: Yes, there most certainly is. So I believe that course is very near to be rolled out and that should provide, if it hasn't been already, and that should provide some good information, as well, with additional examples.

Another question was submitted that beginning 1-1-2011 GHPs are required to report active coverage individuals who are over age 45 instead of using the age threshold of 55. Does this requirement go back to anyone who was an

active covered individual on or after 1-1-2009 or is it just for those who are an active covered individual on 1-1-2011?

So essentially you are just reporting those that are active covered individuals as of 1-1-2011 with this age threshold change. If their coverage terminated prior to 1-1-2011 and prior to this new age requirement of 45 then you do not need to report them. However, if their coverage is still in effect as of 1-1-2011 and they have turned 45 then report, you may report the earliest date that they attained that coverage in the effective date. The system will account for the person's age when determining a late submission indicator.

Bill Decker: Hang on a second, Pat?

Pat Ambrose: Yes, I mean Barbara is pointing out to me that as is covered in the User Guide, I'm referring to just this age threshold, but please see the reporting requirements related to active covered individuals and reporting of Medicare beneficiaries that are under age 45 who you know are Medicare beneficiaries already because you may have been given that information by the individual during your coordination of benefits, collection activities, or you've paid a secondary claim or this individual is known to be entitled due to ESRD. So, again, I was referring to the circumstance if none of those conditions were met and you're just looking at the age threshold. So to be completely accurate please do review the definition of active covered individuals in the User Guide.

Bill Decker: That's the important piece, right.

Pat Ambrose: Right. An individual was asking that they process claims for clients that have primary coverage through another insurance company and they process on any supplemental amount that is applied to the deductible including hospital, medical, and drug claims, what coverage type to be used when reporting for these clients?

I'm not sure that I fully understand the question, but it seems that you would use the applicable comprehensive coverage type if you are actually processing claims for hospital, medical, and drugs it sounds like comprehensive coverage

type to me and you would use the coverage type of W or 4 that includes hospital, medical, and prescription drug coverage.

We don't care that you're reporting GHP coverage that may be secondary to other GHP coverage, where in the case where Medicare is actually the tertiary payer. The coverage type depends on the coverage type supplied by the GHP insurance.

Another question was submitted regarding the platform for the mainframe HIPAA eligibility or HEW, H-E-W software, that can be used to submit the query only file. This software can be or is supplied in a PC server, a Windows PC server version and a mainframe version, but not AS400, Linux, or Unix version. And so the question was specifically what mainframe operating system are you referring to? And we're referring to the standard IBM mainframe operating system such as ZOS or ZVM, but not the Unix-like operating system, such as Open Solaris, Linux, AIX, etcetera. If you have questions about what platform the mainframe HEW software will run on please contact your EDI representative for more information on that.

Also, a question related to the HIPAA eligibility wrapper software and how to execute this software from a command line process. We've covered this on previous calls. I'll read the command line for you and I'll follow-up to make sure that the documentation that you download when you download the HEW software from the COB secure Web site includes this information.

But you execute the HEW software from a command line process. You use the command HEW.EXE -ON. The -O indicates that this is the outbound version or outbound conversion to the 270 format, and the N indicates that it is a non-GUI presentation. So, again, when you are converting a file, a flat file to the 270 format from a command line process you use HEW.EXE -ON.

Likewise, when you get your response file back and you're converting the 271 to the flat file format you use HEW.EXE -IN. The I indicates that this is the inbound conversion from the 271 format, and the N indicates that this is a non-GUI presentation. The files are already defined in the associated (INI) file and can be altered as per the instructions, the downloaded instructions.

Again, if you didn't catch that, I know it's kind of complicated to listen to that and write at the same time, your EDI representative has that information.

Another question related, not specifically to the HEW software but generally speaking to the X12 270, 271 format used for the queries. We are currently using the 4010 A-1 version of the X12 270, 271. There is not a scheduled date for the upgrade to the 5010. The User Guide had indicated possibly January 2011, that has been removed from the User Guide at this time. I have no date for the upgrade to the 5010 version. Again, this language was removed from the User Guide Version 3.1 that's about to be posted.

RREs will be given at least six months' notice of this upgrade, and even with that this kind of upgrade includes a long testing phase and the old and new versions being accepted for a certain period of time. In addition to that, any changes that are needed would be released in a new version of the HEW software, of the HEW software, as well.

Now, all that said, I have been told that possibly the 5010 version does not include or affect the X12 270, 271 but this is way beyond my expertise. So there might never be an upgrade to the 5010 version. But, at any rate, stay tuned, you'll be given plenty of notice. The HEW software will be updated and, of course, the companion guides that are posted out on the Web site.

OK, so that's all I have. I'll turn it back over to you, bill.

Bill Decker: Well, thank you, Pat. That was nice and short, and not that complicated, right?

I'm going to give you a general overview of the Section 111 changes for HRA reporters. There were a number of questions that came in, and some of them, with some of the questions it was clear that the people asking the questions weren't quite sure, weren't quite clear on the concept of HRA reporting, and others just had interesting but relatively specific questions, that is questions that would be specific to their situations.

So I'm going to give you a brief overview of HRA reporting and tell you what happened between the last time we talked about this, which was in March, and

now. We posted an alert on our Web site in May, at the end of May, describing to you the reporting requirements for HRA coverage. It was at that time that most of you who knew about HRA reporting prior to that date discovered that we were no longer talking about embedded HRAs or freestanding HRAs.

As Pat talked, as Pat mentioned somewhat earlier in this description, we did do that, we did drop that distinction because quite frankly it became clear to us based on our both internal discussions here and discussions with members of the industry that for reporting purposes it really didn't make a difference whether an HRA product was freestanding or was attached to somebody else's insurance product.

Whoever the RRE is going to be for that reporting is going to report that HRA to us, report about the HRA to us, and so it becomes simply a question of are you an HRA responsible reporting entity. If you are a responsible reporting entity for HRA coverage you will register with us and report to us under Section 111.

If you're, and pardon me out there in Montana for using you guys again as my stalking horse here, but if you're the Blue Cross Blue Shield of Montana and you sell products to some employers that include an HRA component you can report along, You can report to us under Section 111 your HRA business, just as you report your other GHP business. As we point out, you will be reporting your other GHP business, your regular report "GHP" business under one reporting type and your HRA business under another. It may be necessary for you to submit two records for an individual who has both types of coverage, but you can do it on one file.

For those of you who are not the Blue Cross Blue Shield of Montana or for those of you who are freestanding HRA administrators, if you determine that you are an RRE and will need to be reporting to us under Section 111 you register and report regardless of whether or not that beneficiary has any other insurance coverage that is reportable by someone else. You would still report to us even though or whatever that the beneficiary has other GHP coverages being reported by another RRE.

Remember in general that you're only going to be telling us about Medicare beneficiaries, either a working Medicare beneficiary or a Medicare beneficiary who is a spouse or dependent of a worker that is an employed person. GHP coverages is linked to employment. We don't want to hear about retiree coverage. We don't want to hear about the source of coverage that are not linked to Group Health Plan coverage in general.

Again, the effective date for reporting for HRA coverage is 10-1-10 or later. We – the threshold amount for reporting is $1,000 or more. If it's a thousand dollars or more on 10-1-10 that's when you would begin reporting it. If a beneficiary, a Medicare beneficiary or covered dependent accrues up to an HRA of over a thousand dollars at some point you would then begin reporting it, providing it started after 10-1-10.

All right, the HRA – the RRE will report, as I said before, regardless of who the RRE is. If it's an insurance company doing other types of insurance, that's the RRE. If we're saying that's the RRE it makes no difference from a reporting perspective.

All HRAs will report using the R coverage type on field eight of the MSP input record file. So if you're an RRE, you're an HRA, RRE and are reporting to us, the coverage type you are reporting will be R. There are other coverage types for other types of insurance. If HRA coverage, though, you're going to be using that R coverage type.

Now, we do have some other specific questions but in the interest of time, it now being 45 minutes to go before we're – we have to conclude this call, I do want to open it up to questions. If you have other permutations of questions on HRAs this is your opportunity to ask them.

(Barbara Wright, who is here with us also this afternoon, has a (inaudible) about reporting GHP coverage in general and when it includes ESRD coverage, and I'd like to have her explain that to you now, if she would?

Barbara Wright: Generally for ESRD you're not looking at employer size or employment status, so that's your one big exception for ESRD. You need to be aware of that, and if you go back to the User Guide it goes through it in more detail.

Bill Decker: Right. ESRD, of course, is end stage renal disease, and you can be a Medicare beneficiary if you are diagnosed as having end stage renal disease.

We did have one other question, which I'll get to briefly, which is someone asked us about a disability. A newborn who is diagnosed as disabled, and asked when does the coverage start, when do they have to be reporting, etcetera?

The disability designation for Medicare will be made by the Social Security Administration, not by us. And at that point the newborn would get – if there was a disability diagnosed and assigned by the folks at the Security Administration the person with the newborn would get a social security card and, thus, would become eligible for Medicare at that point. Before that there's no reporting of that.

(Robert): But let's back-up a little. For an infant, about the only time a child is going to be entitled to Medicare is if they have ESRD and are getting benefits on their parents' record. Children often get SSI through the Medicaid program, but children do not normally get Medicare. In order to get Medicare you normally have to get it on the basis of disability, you have to be insured on your own record or there are spousal benefits for divorced, widows and widowers, etcetera, on a spouse's record.

So normally unless you worked and paid into the social security system you aren't going to be able to get Medicare unless it's through a spouse. There are certain categories of adult disabled children that occasionally get benefits on their parents' records, where they had full disability established before they reached their maturity. But for children it's normally only going to be if they have ESRD and are getting Medicare on their parents' record.

Bill Decker: Hey, great. Thanks, (Robert), on once again showing the nuances to the coverage determinations are oftentimes somewhat complicated.

Does anyone here else have anything that they want to say before we open it up? Nathan?

Nathan Crawford: This is Nathan Crawford. I work with MSP recovery, and I just wanted to let everybody know that we will be making a major change to GHP recovery. And we'll be announcing that soon.

If you'll look on the www.msprc.info Web site we'll be posting a webinar soon, towards the end of July. And this does not relate to HRAs, it will be regular GHP coverage, and the normal people that receive GHP demands this will affect the entire recovery process for the GHP, so stay tuned to that Web site and we'll be announcing that webinar soon.

Female: But please don't get too excited. We think this is a change you'll actually like, so it –

Bill Decker: Well, you can get excited about that, actually.

Female: Well, but to make the process easier and to avoid sending demands when they would be inappropriate. So stay tuned, but we believe it's an improvement to the process that the insurance industry will receive favorably.

(Nathan Crawford): Yes, (inaudible).

Bill Decker: OK, thank you very much.

Operator, we'll go to the question-and-answer phase now.

Operator: OK. If anyone would like to ask a question please press star one on your telephone keypad.

Your first question comes from (Liz Tucker) from (Gotham City Productions). Your line is open.

(Liz Tucker): I actually e-mailed a question. I think it was one of the more specific ones. We have one employee who is over the age of 65, and we give her $150 a month so she can purchase her own supplemental insurance. We don't sponsor any insurance, we don't have any insurance through our company, so

she just simply goes out and purchases her own. And my concern is HRA and do I need to report her?

Bill Decker: We asked this question, your specific question, in fact, of our policy and regulatory expert here, who unfortunately is not here today. But he did tell us that under – as far as he understands, based on your question, yes, you would have to report –

Pat Ambrose: I actually have the answer.

Bill Decker: You have the answer?

Pat Ambrose: His response verbatim was the arrangement described, the employer gives the beneficiary employee money to buy a Medigap policy does constitute an employer sponsored GHP.

(Liz Tucker): OK.

Pat Ambrose: The reference to 42 CFR 411.101, the arrangement between the employer and the Medigap plan is primary to Medicare and is responsible for full charges. The employer should be listed as employer and insurer. Providers, physicians, and other suppliers should bill the employer, and the employer is responsible for full charges.

(Liz Tucker): OK.

Male: That's fine.

Pat Ambrose: OK?

(Liz Tucker): OK, thank you very much.

Pat Ambrose: You're welcome.

Operator: Your next questions comes from (Jim Miller) from (SADC). Your line is open.

(Jim Miller): Yes, I actually submitted this, as well. And I'm kind of late in the game. I have done my registration and so forth. But we have just two clients that are actually fairly small but large enough to where according to the regulations I would have to file their MSP for their HRA. However, I'm probably talking about maybe a total of six or seven people. Is there any kind of software or a way that we can report that without having to design some sort of a system to send you all this information?

Bill Decker: There is no way for a GHP reporter, a small GHP reporter, to submit their information to us in any other way than any large GHP reporter would. They're – GHP, unfortunately, which is what an HRA is, the reporting system that is described in the User Guide is the one that you will have to use.

In the future we do intend to be able to set-up some sort of a system for – I'll get to that in a minute, (Cindy) – we do intend to set-up a system where if there is a limited number of claims that – or people that you're going to have to report on, there may be some sort of a direct data entry option available. But for GHP direct data entry, which would be what you'd probably be looking for, is not available at this time, unfortunately.

(Jim Miller): Yes, that is important. OK. Thank you.

Operator: Your next question comes from (Sonia Pecksanow) from (Primary Care). Your line is open.

(Sonia Pecksanow): Good afternoon. How are you?

Bill Decker: Good. Thank you. Go ahead?

(Sonia Pecksanow): We're a TPA, we act like an HRA but we're not truly an HRA. What we do is we work with our clients to purchase a high deductible plan and self-fund some of that deductible with employer money. So, for example, we will purchase a plan from Blue Cross Blue Shield that has a $3,000 deductible on it, and the company says if you are enrolled in this plan and you select this option we'll pay $2,000 of that $3,000 deductible. Are we in the position where we need to report to you?

Bill Decker: It's not a standard issue HRA product, however, is that what you're saying? It's not set up under the IRS rules?

(Sonia Pecksanow): Exactly.

Bill Decker: It's just the employer voluntarily paying some money to the insurer?

(Sonia Pecksanow): Yes.

Bill Decker: Is this after the employed person pays the premium or before the employed person pays the premium?

(Sonia Pecksanow): Well, the employee will have to pay payroll deductions in order to enroll in the Group Health Plan. And all of the claims will have to be processed through the Group Health Plan first and posted to the deductible, and then will be processed in the claims after that.

Bill Decker: It's –

(Barbara Wright: We can go back to, as we said, our policy, top policy experts for GHP, but that sounds an awful lot like a variation on what we just talked about. In general, when you're talking about a GHP it's where an employer sponsors, contributes to, or facilitates. And certainly when there's payroll reductions, when they're paying out money, all of those conditions do seem to be met, but we will go back and talk to our policy expert on this. Who, as we said, unfortunately is not here today.

(Sonia Pecksanow): Should I send an e-mail with the question?

(Barbara Wright: I think this one is already one of the ones we received. Have you sent this one?

(Sonia Pecksanow): Not in great detail. I've sent something, yes. But –

Barbara Wright: If you're going to resend it with more detail could you include your prior one at the bottom so we know?

(Sonia Pecksanow): Yes.

Bill Decker: And we will – this is a wrinkle in the reporting system that's important to us to get resolved. So, yes, we'll respond to this and report back.

(Sonia Pecksanow): Will I get a response directly or do I have to wait till the next call in order to find out what the answer is?

Bill Decker: We'll make that determination when we see your question. That's all we can say here in public, OK?

Operator: Your next question comes from (Connie Gilchrist) from (InfoSource). Your line is open.

(Rich Glass): Hi, this is actually (Rich Glass). I'm here with (Connie). Thank you very much for today's call. We are an HRA RRE, and had a couple of follow-up questions to the excellent guidance that you've just gave.

First of all, relating to the October 1st effective date. If you have an HRA with a calendar plan year and the employer hires several people, say, in September and their first effective date of HRA coverage is the first of the month following their hire date, which would be October 1st, would you include those people in the fourth quarter report?

Pat Ambrose: Well, I had said that it's reflective of the HRA plan year, which is January 1. Now, I'm going to turn to Bill Decker and make sure that he agrees with that, so –

Bill Decker: I agree with that.

Pat Ambrose: So you'll be reporting everyone in your first quarter file, and those individuals that had an effective date because of being hired later in the year, you'll wait to report them with everyone else.

(Rich Glass): OK, and, Bill, earlier you talked about the timing of an assigned file submission timeframe. So if you had a timeframe that was, say, late November or even early December and you had a November 1st plan year would you report that in the fourth quarter or would you wait until the first quarter of 2011?

Pat Ambrose: If you're able.

Bill Decker: Yes.

Pat Ambrose: I mean there is a 45-day grace period. If you're able to report it and taking that grace period into account certainly we want it. If you're not able to report it then it would be first quarter 2011.

Barbara Wright: Remember, as Bill Decker said before, regardless of whether something is reportable because of the threshold or you have a timing issue, if you have an HRA where it is primary to Medicare there's a duty on you to make sure that it's expended appropriately and pays before Medicare does. So it's to your benefit to make sure everything is reported as soon as it can be reported.

(Rich Glass): OK. Thank you. To the extent that an HRA employer has fewer than 25, excuse me, fewer than 20 employees and has no ESRD beneficiaries, that employer's HRA would not be reportable, would it, not? If it's just under 20?

Barbara Wright: If it's not in any way a multi-employer HRA then as long as you accurately counted employee five, what you say is true.

(Rich Glass): OK, and then finally we're running into some resistance, as I think a lot of HRA RREs are, about obtaining spousal Social Security Numbers and or HICNs, as well as dates of birth to determine the 55 and 45 thresholds. What do you do if someone obviously does have a Social Security Number? They just don't want to give you?

Bill Decker: The general rule on collecting this sort of information is what we've spelled out in a lot of previous calls and we'll do so again here. First of all, we need the Medicare HICN if it's available. Secondly, if it's not available we can do a query using an individual's Social Security Number. But our primary identifier is the Medicare ID number.

The only reason we would be querying on an SSN would be to find out if the person that has been sent to us in the query is a Medicare beneficiary. If the person is identified as a beneficiary, whoever sends us the SSN the query on

will get the individual's Medicare health insurance claim number, Medicare HICN back, and that individual will then – we then require you, the next time you report, to send, to use the HICN rather than the SSN.

In your efforts, in anyone's efforts to collect this sort of information from people in the real world there we have heard of, quite obviously, instances where people are reluctant to give-up these ID numbers for any variety, a large variety of reasons, actually. We would remind Medicare beneficiaries that in order for them to participate in the Medicare program they do need to give their Medicare ID number to someone who is asking for it legitimately, and that would be an insurer. And in this case a GHP insurer, in this case the HRA administrator.

That is important to, for everybody out there to understand. The analogy, of course, is that if you are anybody who is covered by insurance and someone asks you for your insurance ID number, you give them that number or else the insurer will not pay. That's the same way here with the Medicare ID number, the Medicare HICN. That's something that can be said to people who are reluctant to give-up ID numbers.

If, however, there is still resistance and if an individual is reluctant to provide a number that you need to have in order for you to be complaint with Section 111 there's a document on the Web site that you can give to the individual that they can sign and give back to you, which says that they are not giving you the numbers you're asking for. You need to keep that documentation with you or at your place of business or in general keep it for your business reasons because if we ever come back to you and say, "Why didn't you report this person?" You can then produce that and say, "This is why." Other than that, we can't really give you much more guidance.

Pat Ambrose: The model language –

(Rich Glass): Where is that document?

Pat Ambrose: There are documents on the Web site related to what Mr. (Decker) just reviewed, so you go to www.cms.gov/MandatoryInsRep and on the two alerts, related alerts happen to be on the What's New page. So if you look over on

the left-hand side of the page and go down to the tab or the link that says MMSEA 111, What's New, and then go to the bottom of that page there's a download section. And the alerts, the first one is dated August 18th, 2009 MMSEA 111, HICN SSN Collection, GHP model language. And the other is dated May 26th, 2009, Alert Compliance, Compliance Guidance Regarding obtaining individual HICNs and, or SSNs for GHP reporting. And you should read both.

(Rich Glass): But Mr. (Decker) mentioned a form that they can sign, where is that form?

Barbara Wright: That's what Pat is giving you the information on.

(Rich Glass): OK.

Barbara Wright: It is not technically a form. It is model language that we are suggesting that you use. You need to look at both – the reason there's two documents, one is the actual alert that tells you about what our requirements are, and the other one is the actual model language. And you will find both of those downloads on the What's New page.

(Rich Glass): OK. Thank you. One last question related to HRAs again. I don't know how familiar you are with health savings accounts, but there's a concept of a limited purpose HRA that would pay only dental, vision, and preventive care expenses. And I think none of these expenses really are covered under Medicare so if you have an HRA –

Bill Decker: We're talking about what has to meet the IRS definitions of a health reimbursement arrangement, and it would be used to fund services for which Medicare would make payment. If Medicare does not make payment for a service there would be no HRA, no Medicare involvement. We'll move on to the next question now.

(Rich Glass): OK. Thank you.

Bill Decker: Operator?

Pat Ambrose: Operator?

Operator: Your next question comes from (David Pittman). Your line is open.

(David Pittman): Thank you. My question is again about HRAs. I believe when Bill was talking about the subject he said something about circumstances where we would submit two records for the same person, and that's where I got confused. If a person has both traditional medical coverage and an HRA and HRA coverage under the same plan, simultaneously, just one plan, one person, would there be any reason to submit two records for the same person?

Bill Decker: Would there be any reason to?

(David Pittman): Yes, is that what you're requiring, to give you separate records for the same person, same period of time, the only difference is there's two different coverages under the same plan?

Barbara Wright: And we're secondary to both of them.

(David Pittman): Well, no, you're secondary to the plan. There's only one plan, it just has two different types of coverage.

Barbara Wright: We're secondary to the coverage under the HRA part. We're also secondary to the coverage under the rest of the plan. And both should be expended appropriately before we pay any type of payment, which in this particular case would actually be a tertiary payment.

(David Pittman): Well, it's a secondary payment because there's only one plan.

Bill Decker: There's one overarching plan with two components, David. That's the way you need to consider it I think. We do have – we've answered this question before, and the answer is always going to be the same. If there's HRA coverage in association with other insurance coverage, both types need to be reported. They can be reported in the same file but they need to be separate records for reporting.

Operator?

Operator: The next question comes from (Albert Tolson). Your line is open.

(Albert Tolson): Yes, thank you for taking my call. I have a very short question. How do you handle in the response file when the HICN number in the social match each other? Is that an error or it's OK?

Pat Ambrose: Well, it really shouldn't happen. Make sure the HIC number usually, very often the HIC number is, of course, based on the Social Security Number but it has a suffix at the end of an A or a B, or something like that.

(Albert Tolson): So when we're updating our file we have the HICN number, we should provide for the suffix along with it if the social and the HICN match?

Pat Ambrose: Yes.

(Albert Tolson): OK.

Pat Ambrose: Yes, I mean the HIC number, you know, like I said, is generally there's many different formats for it but it generally is a Social Security Number followed by a letter of A or B or something along those lines.

(Albert Tolson): OK. Thank you very much.

Pat Ambrose: You're welcome.

Operator: Your next question comes from (Paula Freeman) from (Rosenveld Einstein). Your line is open.

(Paula Freeman): Yes, thank you. I actually have a couple of questions. We are an RRE just because we do freestanded HRA administration. If there is a short plan year, let's say we have a new client that wants a short plan year to migrate them to a calendar plan year, would we report eligible individuals the first quarter of the new short plan year and then the first quarter of the full plan year?

Pat Ambrose: Well, generally the way the GHP, MSP file reporting works is that once you have reported coverage, if it remains the same from year to year you just leave the record open. So let's suppose that the short plan year started October 1st and you reported in fourth quarter 2010, and you reported an effective date of October 1st, 2010 for all of these individuals. And then starting January 1 the plan year starts over again and it continues on. If it is the same coverage for

these individuals you just leave the record open with no termination date. In other words, put zeroes in the termination date. And if it's exactly the same coverage going forward you don't need to do anything actually if you've left a record open other than send updates with termination dates or changes as are applicable.

(Paula Freeman): OK, and that would be true even if the short plan year started, let's say, April 1?

Pat Ambrose: Yes.

(Paula Freeman): And then the following year was the calendar year?

Pat Ambrose: Yes.

(Paula Freeman): OK, and then my second and final question is if an individual turns age 45 mid HRA plan year is this a change on the reporting file?

Pat Ambrose: It's – yes, it could possibly be. If they are defined as an active covered individual, once they become one the next quarterly file that you are submitting you need to consider them for reporting. Now, there's two methods. One is using the definition of active covered individuals and just reporting those individuals on your MSP file or you could instead use the finder file method approach first and first query them, and if they're matched to a Medicare beneficiary then report them. You have a choice. The use of the query file is optional, although recommended.

So you need to consider every time you create a quarterly file, every time your quarterly report comes around you need to consider who is my set of active covered individuals that I need to consider for reporting. So you might suddenly have to report someone midyear. In that case you can use an effective date of when that coverage first became effective and, again, the system is to look at the individual's age and realize that, well, you didn't report them before because they weren't of the age threshold and so on so you should be OK.

(Paula Freeman): Thank you.

Operator: Your next question comes from (Lisa Leggen) from (Jaker and Flynn Associates). Your line is open.

(Lisa Leggen): Hi. Thank you. We are RREs because we are HRA administrators, so we are preparing, we're registered but we're at the beginning stages of all this. I have a – I really want to be certain by the time we're done here that I truly understand when we begin reporting. If our assigned reporting submission deadline is the 15th of the first month in each quarter, so if we have plans that renew on October 1st we should be reporting them on October 15th, and then November, December, and January effective dates we will need to report on January 15th?

Pat Ambrose: Well, in actuality there is a 45-day grace period for reporting new information.

(Lisa Leggen): OK.

Pat Ambrose: So you could, and what would make the most sense in your case is to report everyone in your January file.

(Lisa Leggen): Including the – what about the – I'm thinking we have approximately 10,000 participants that we re-enroll for January, that's – we usually are even done getting them in our system by that time, that's what I'm trying to prep our staff for.

Pat Ambrose: OK, so those that are renewing in January and again you have this grace period, if you're not able to report them all in January then those would be reported in your next quarter, so it's really a matter of the earliest that we want you to report and if you can report those with effective dates of October 1 you can report those in your October 15th file.

(Lisa Leggen): OK.

Pat Ambrose: But if you're not able to you don't have to report them until first quarter 2011 in your January 15th file.

(Lisa Leggen): OK.

Pat Ambrose: Now, those that become, who have effective dates of January 1st you, again, because of this 45-day grace period technically if you're unable to get them on that first quarter file by January 15th you can wait and do it April 15th.

(Lisa Leggen): OK. I'm going to sleep a lot better at night now.

Pat Ambrose: Good.

(Lisa Leggen): My second question for right now would be if I understand what I've read through the manual correctly and what I'm hearing, we have quite a few clients whose benefits might be a $750 benefit for someone who is enrolled in individual health insurance coverage, and it might be $1,500, say, for family, something along those lines. So we've got people who are under and over the thousand dollar threshold. It sounds like we're going to be collecting data on everyone, but when we go to send you the file we are only going to – we have to sort through all of that, and we're only going to report to you the people who are over the thousand mark?

Bill Decker: And who are Medicare beneficiaries.

(Lisa Leggen): And who are Medicare beneficiaries, OK. OK, I wanted to make sure I understood how detailed the sorting is that we've got to do ahead of time.

Female: Do you have anything else real quick?

(Lisa Leggen): I think we're good. Thank you.

Bill Decker: OK. Thank you.

Operator: Your next question comes from (Daniel Kornfeld) from (Glickman and Penn). Your line is open.

(Daniel Kornfeld): Good afternoon. Thanks for taking my call. I'm an Attorney in Upstate New York. I represent several multi-employer welfare plans. They have group health coverage. They usually purchase it through an insurance company, but they set-up HRAs for their members. It's 100 percent employer contributions. The Group Health Plans are reporting the Medicare secondary payer information from the – for the participants in the Group Health Plans but

they're not reporting anything related to the HRAs. Are these multi-employer welfare plans also supposed to report?

Bill Decker: Yes, the HRA administrator will be reporting on behalf of the members who have, who are covered by the multi-emploeyr welfare plan and who have HRA coverage.

(Daniel Kornfeld): Now, if they contract with a separate company to do that, they just supply the information to that company and that company reports directly to CMS?

Bill Decker: That company that – in the scenario you just described we would consider the company that's reporting to CMS a third-party administrator, yes, and that would be the RRE in this case, and that would be the reporter.

Pat Ambrose: Yes, please review the definition of a responsible reporting entity for GHP reporting in the User Guide and determine who the RRE is. Now, once you've established who the RRE is they may contract with an agent, a reporting agent, to report on their behalf. However, the RRE retains full reporting responsibility for the reporting, but you may use a reporting agent to submit that information for you.

(Daniel Kornfeld): Am I to understand that the distinction between embedded and standalone is no longer applicable?

Pat Ambrose: Correct.

Bill Decker: That's correct.

Pat Ambrose: And that's published in an alert on the Web site as of right now, MMSEA 111 alerts page.

Bill Decker: Right.

(Daniel Kornfeld): OK. Thank you.

Operator: Your next call comes from (Fran Folec) from Horizon Blue Cross. Your line is open.

(Fran Folec): Thank you very much. I'm switching the topic. This is regarding the non-MSP response file detail record. And I'm curious to know why and could it be changed, in the individual policy number field, field 10, we only receive that number back which we do submit on the outbound file if the action type is D or F. We don't get it back if it's an N record. And for our comparison reporting and balancing we need to be able to find the – go back to our subscriber. But if the record is only, let's say, a spouse we have difficulty tying it back to the subscriber. And we were wondering could we – could there be some thought put into giving back the individual policy number on N records or what was the reason for not supplying that on a response file?

Pat Ambrose: Well, I guess it wasn't supplied because the N record functions as a query and maybe the thought was that it wasn't necessary. This is the first time anyone has suggested it. So that said, we can take it under consideration. I don't have right – is there a document control number on that?

(Fran Folec): There is a document control number, and, yes, we could tie it back to the file, the non-MSP file we send to you, but that would involve a lot of programming on our part as opposed to just finding the subscriber on our master files.

Pat Ambrose: Another option might be using the – putting the plan ID in the document control number, you know, instead of making up some number for the DCN you can put maybe your – that policy number in the document control number on your end records.

(Fran Folec): OK, that's all from another change and more programming?

Pat Ambrose: Well, yes, I'm aware of that.

(Fran Folec): I like that idea, but I'm looking to do it at the lowest cost.

Pat Ambrose: Yes, well, I'll take it back, but a change like that is also a cost on this side.

(Fran Folec): Right.

Pat Ambrose: So it would have to go in the queue. And would you also do me a favor if you haven't – I don't think you have or at least not as of yesterday, submit that question to the Section 111 mailbox?

(Fran Folec): I did submit it yesterday. You may not have seen it because I didn't send it till about 3:00.

Pat Ambrose: OK, so that's great. And we'll take a look at that and see what we might do. I don't think it would be a big change but obviously I can't make promises like that either, so all right. Thank you.

(Fran Folec): Thank you very much.

Operator: Your next question comes from (Ray Maddock) from Hewitt Associates. Your line is open.

(Ray Maddock): Hello. Thank you for taking my call. Could (Nathan) repeat that Web site where the webinar is going to be in July, please?

Pat Ambrose: He has left the room but I can repeat it for you.

(Ray Maddock): Thank you.

Pat Ambrose: It's www.msprc.inso, so it's the msp.rc.info is the Web site.

(Ray Maddock): Thank you very much.

Operator: Your next question comes from (David Smohlers) from Discovery Benefits. Your line is open.

(Sandy): Thank you for taking the call, and this is (Sandy). (David) left the room. Just a quick clarification question. If an individual has a covered amount that's less than a thousand that they roll over funds from the prior plan year, so they become a thousand dollars or greater, we understand they have to be reported individually. Then just the last piece of clarification was if they spend some of those spend, so they go back under the coverage level do you submit that on the changes file to remove them?

Bill Decker: Remove them? I wouldn't remove them. We would not ever counsel anybody to remove someone in that circumstance because, in fact, even though it's now under a thousand dollars it's still a primary payer to Medicare and it's still showing Medicare that Medicare will be a secondary payer.

The only time we would ask you to terminate a record on an individual is if the individual is no longer eligible for the HRA and no longer has it or if they don't renew at the end of a plan year or something like that.

Pat Ambrose: And let me add a – some clarification about deletes versus termination. To indicate that coverage has come to an end, it did exist and now it has ended, you send an update record with a termination date. The delete is only used if it was erroneously reported originally.

(Sandy): Got it.

Pat Ambrose: OK.

(Sandy): So probably for the rest of the plan year if they exceeded that thousand dollars at any time during the plan year?

Bill Decker: Right.

(Sandy): OK, that's what we wanted to know. Thank you so much.

Operator: Your next question comes from (Rebecca Roth) from American Benefits. Your line is open.

(Rebecca Roth): Hi, this is (Rebecca). Thanks for taking my question. I was the one that sent the question about processing claims that have primary coverage that are fully insured through another insurance company, and what we do is process supplemental, claims that have been applied to the deductible by the primary insurance company. And no matter what type of claims they are as long as they've been applied to the deductible there is an underlying plan that we process.

Now, I want to make sure, we are to report those if they have over 20 employees, correct?

Bill Decker: Yes.

Pat Ambrose: Yes.

(Rebecca Roth): OK, because the other lady's question was just similar to mine, and you told her to write an additional question to you. So we are to report them, and depending on what type of coverage we pay it should be either a W or a 4?

Pat Ambrose: Yes.

(Rebecca Roth): OK, I just wanted to verify that I was correct. OK. Thank you very much for your help.

Operator: Your next question comes from (Stephanie Stemmey) from (Highlark). Your line is open.

(Stephanie Stemmey): Hi. I had a question in regards to the small employer. We've been having a terrible time trying to get ours approved, and well we actually have the small employers being approved but when we're sending them out on our MSP file we're getting them all back as being denied. I was wondering if it would have anything to do with when we fill-in the tax ID number we are using the multi-employers' tax ID number. And when I was reading the document it does say that when they compare for the small employer approval they use the HIC number and that individual employer's tax ID number.

Pat Ambrose: Yes.

(Stephanie Stemmey): OK, is that our problem?

Pat Ambrose: I think it might be. Can I have your RRE ID, please?

(Stephanie Stemmey): Yes, five zeroes, and 3904, SS 3901 and 5100.

Pat Ambrose: OK, five zeroes, and again say that again?

(Stephanie Stemmey): 3904.

Pat Ambrose: OK.

(Stephanie Stemmey): And then the other one is the five zeroes and 3901.

Pat Ambrose: OK.

(Stephanie Stemmey): And then the other one is five zeroes and 5100.

Pat Ambrose: OK, yes, let me look into that. I think I – that the small employer exception is in the system under the individual employer EIN, but your incoming file is using the plan sponsor EIN and the two do not match.

(Stephanie Stemmey): Right, and we're having – I mean all of our people now that for years have this, all their plans are denying. And we called the small employer group, and they've now told us we're no longer allowed to call that section, that we have to call Medicare. And Medicare says, no, they won't help us.

Pat Ambrose: OK, well, we'll make sure you get some help.

(Stephanie Stemmey): Thank you so much.

Pat Ambrose: You can't be the only one experiencing that problem.

Bill Decker: Yes.

Operator: Your next question comes from (Regina Deal) from (Forest Insurance). Your line is open.

(Regina Deal): Good afternoon. I just wanted to clarify another question that an individual had asked. If an employer is – has an individual over 65 who is not on their Group Health Plan, they are in turn giving them an allocation to purchase the Medicare supplement, that needs to be reported to CMS?

Bill Decker: Yes, according to our regulatory advisor it has to be reported.

(Regina Deal): OK, and what was the reference number? I didn't catch it?

Pat Ambrose: Give me a minute and I'll find it. But we could go on to another question, if there is.

Operator: OK, your next question comes from (Francine Ruvall) from Horizon Blue Cross. Your line is open.

(Francine Ruvall): Hi. I was wondering, can you hear me or am I on mute?

Pat Ambrose: Yes, yes, we hear you.

(Francine Ruvall): OK, I'm sorry. I didn't know they took my question. You said that if a person refuses to provide their Social Security Number that we should obtain a signed document from them stating that they're not eligible for Medicare?

Bill Decker: No, no, no, it doesn't say that. It says that they're not giving you their number.

(Francine Ruvall): Oh, it just says they're not –

Bill Decker: Right.

(Francine Ruvall): Do we have to question them every year or can we just question them once and keep that on file?

Bill Decker: We ask, we advise you to question them at least every year.

(Francine Ruvall): At least every year?

Bill Decker: Right.

(Francine Ruvall): OK. Thank you.

Pat Ambrose: Before we go on to the next question, the reference to the arrangement described about an employer that gives an employee over age 65 money to buy supplemental insurance, the reference is 42 CFR 411.101, so hopefully you'll find what you're looking for there.

We can go on to the next question. Thank you.

Operator: OK, your next question comes from (Janine Har). Your line is open.

Bill Decker: Let's move on then, Operator?

(Janine Har): Oh, I'm sorry, are you there?

Bill Decker: Yes.

Pat Ambrose: Yes.

(Janine Har): I'm sorry about that. Actually, I have two quick questions. The first question is we work with a bunch of employer groups that have registered and spoke with our EDI representative, and their representative was telling them they would not have to complete reporting. These are groups that were over 20 and reimbursed in most cases deductible only but in the amounts over a thousand dollars. Is there any reason they would have been told they wouldn't have to report?

Bill Decker: It would have been incorrect information if they had been told that.

(Janine Har): OK, all right. And the second question we also do work with some cases where the carrier reimburses, actually has HRA administration available, however, they will not reimburse 100 percent of the deductible, so the employer ends up doing a self-administration on the backend. If both the carrier and the carrier's HRA that they're administering and the employer's HRA are both under a thousand dollars but combined they're over a thousand, how would that be handled? Should either report, should both report?

Bill Decker: You mean, well, the insurer is – describe what the insurer is doing one more time?

(Janine Har): Once companies offer HRA administration …

Bill Decker: Yes.

(Janine Har): – through companies that they've acquired. So they're doing HRA administration, however, then the employer also is if the carrier's administration will not do 100 percent of the deductible.

Bill Decker: Did you send this into us already?

(Janine Har): No, I did not.

Bill Decker: Would you send it into us, please?

(Janine Har): Absolutely.

Bill Decker: This is a relatively complicated question and we're going to have to …

(Janine Har): Not a problem. Thank you.

Bill Decker: And, Operator, we have time for one more call. We'll take one more call, and then we'll have to wrap it up.

Operator: OK, your final question comes from (Jane Scrop) from Sutton Bank. Your line is open.

(Jane Scrop): Hi, Bill. Actually, you guys clarified a lot for me in January, but I have another question. We're a self-funded HRA. We reimburse only towards the deductible but we only reimburse once the deductible has met $2,200 so the participant is responsible for the first $2,200 and then should claims go above that we reimburse up to when the plan takes over 100 percent, the carrier takes over 100 percent. Will that create incorrect MSP occurrences for the participant? Because like if I report January 1st because my plan year renews January 1st, and let's say that Medicare beneficiary goes into the doctor January 15th, that participant is actually responsible for that claim before the HRA, do you know what I mean?

Bill Decker: Yes, the beneficiary is paying down the deductible by paying the provider, is what you're saying?

(Jane Scrop): Right, right. So with that claim, but from a Medicare perspective our carrier would capture that claim if they know that needs to be applied to the deductible. At that point is it shot over to Medicare? And will Medicare say, "No, no, no, your HRA is primary." Even though the HRA will not start paying until after $2,200 or excuse me this year it's $2,400?

Bill Decker: You would start, the HRA would start reporting to us –

(Jane Scrop): OK.

Bill Decker: – at some point in the future, not at the – that's difficult, that's a difficult one. If you have – yes, once again, I'm sorry, this is a little bit more complicated than we have time for. If you were sitting here in the room with us in the next 15 minutes we could probably hash this out. But, as it is, could you just resend the question?

(Jane Scrop): Sure. Additionally, I sent out February 22nd, but I'll go ahead and resend it to you.

Bill Decker: Yes, resend it to us now and mention that we've discussed it right at the end of the JHP call.

(Jane Scrop): Because I know, I'm actually looking at TPAs right now because I'm going to be outsourcing our HRAs so I can become compliant with the reporting next year. And I know a lot of HRAs are structured where the participant first had a portion of the deductible before the HRA actually kicks in, so I believe it's pretty common.

Bill Decker: Yes, I can't answer the question instantaneously and no one else is here at the table can either so we're going to have to take it under advisement and get back to all of you. OK?

Operator: I'll turn the call back over to you.

Bill Decker: Yes, thank you very much.

Thank you, all, for participating. It was very instructive for us, and I hope it was good information for you and that we got at least the majority of your complicated and interesting questions taken care of. As I said, there'll be another call in September, and at that point we can revisit some of this. And those of you who asked questions that we could not answer we will get around to them and get back to you just as soon as we can. Pat Ambrose and I and the other folks who are on this call will – are very happy that we were able to do it and we're glad that the questions that came in were basically answerable.

There's only been a few that have been stumpers, which was very good this time.

Thank you, all, again. And at this point we will sign-off from this Section 111 call. Operator, if you could stay or come back on the line to us after the sign-off and let us know the counts, how many people were actually on the call and how many people remained in queue at the end. Thank you very much, everybody.

Operator: This concludes today's conference call. You may now disconnect.

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