TRANSCRIPT

TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007

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DATE OF CALL: AUGUST 8, 2013

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

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Note: Due to unusually poor audio quality resulting from factors including, but not limited to, speakers off mic, cross-talk, heavy foreign accents, technical terms and participants joining via cell phone signals, this transcript contains some (inaudible) notations.

The instances in which there were problems with the audio which lead to some text not being transcribed have been highlighted in the following transcript.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
August 8, 2013
1:00 p.m. ET

Operator: Good afternoon, my name is (Lisa) and I will be your conference operator today. At this time, I would like to welcome everyone for the MMESA Section 111 GHP conference all.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mr. John Albert you may begin your conference.

John Albert: Thank you operator and good afternoon everyone. For the record, today is Thursday, August 8, 2013. And this is the GHP Section 111 Town Hall Teleconference. As we stated at the beginning of these calls, we have a little disclaimer that says that if we say anything that contradicts the official written instructions of the GHP user guide and other materials on the Section 111 website, again, until that publication is updated, that is still the official policy.

We're not perfect, we sometimes say things that don't match exactly what's on the materials, there's a lot of them. So, again, please refer to the materials. We take the information from these calls, questions whatever to update those user guide as necessary.

To begin today, we'll have a presentation by Jeremy Farquhar the Coordination of Benefits contractor. Barbara Wright wanted to – who's with us as well is going to briefly talk about a question that came in related to the SMART Act. And then we'll open it up to the normal question and answer session. We ask for you to provide your name as well as the company you represent. And please try to limit your questions to one and one follow up question. So that if there are a lot of questions, other people can get their turn of the microphone.

So with that, I'll turn it over to Jeremy.

Jeremy Farquhar: Thanks, John. OK, first off. Most of you are likely aware but for those who might not be, CMS recently reorganized their website and their new URLs for the Section 111 Mandatory Insurer Reporting pages. They're now separate in distinct links for group health plan, GHP, and non-group health plan, NGHP reporting. So the new GHP Mandatory Insurer Reporting pages are located at go.cms.gov/mirghp. There's no www in front of that URL, it's go.cms.gov/mirghp.

There have been also changes regarding access to the computer-based training, CBT modules. Unfortunately, at the present, the online video versions of the CBTs are not available. However, all training materials are readily available in PDF format and may be accessed without any need for registration. Currently all training materials may be accessed by clicking on the GHP training materials link located at the upper left had side of the GHP Mandatory Insurer Reporting page. In related news, a new version of the GHP user guide has now been published and is presently available for download.

New guide may be accessed via the aforementioned GHP Mandatory Insurer Reporting site by clicking on the GHP user guide link found at the upper left hand corner of the page. New version is 4.1 and is dated 7/19/2013. For summary of updates included within the new version, please refer to Chapter 1. And one of those aforementioned updates ties directly into my next topic which is the proper and accurate reporting of coverage termination dates.

For the past several months, it has become evident through data analysis being performed regarding termination dates reported as the first day of the month. But numerous entities are not reporting coverage termination dates in an entirely accurate fashion. The guide has been updated in order to provide additional clarification which will hopefully aid in alleviating any potential confusion. The following is a brief explanation taken directly from Section 7.2.6.1 of the new user guide. The coverage termination date is the last day that the active covered individual is covered through a GHP to the current employment with the exception of situations involving ESRD.

Even though GHP coverage may continue past their last day of employment, for example, the covered individual stops working mid month but retains coverage until the end of the month. The submitted coverage termination day should be the last day that the active covered individual was employed. Medicare becomes the primary payer once current employment ends. OK. So the new guide has also been updated with some example scenarios and is highly recommended that all RREs take time to review and ensure that their current processes are in keeping with the aforementioned guidelines.

In some instances, what we found is the RREs are occasionally reporting the coverage termination date as the day after active employment or coverage had terminated, as opposed to the last day of actual primary GHP coverage. What RREs should be reporting as the coverage termination date is either the final day of active employment through which that coverage is being received, or the last day of actual coverage, which ever happens to come first. One exception to this rule could be a situation where the covered beneficiary is entitled to Medicare based on ESRD and active employment ceases in the midst of their 30-month coordination period. We continue to receive occasional questions regarding HRA reporting requirements.

The following are the basics which you should understand for HRA reporting. Only an individual HRA policy within annual benefit value of $5,000 or more must be reported. If there are remaining funds at the end of an annual period and those funds are rolled over to the following annual benefit period causing that total benefit value to exceed $5,000, then the coverage must be reported. If an HRA coverage is canceled, or the annual benefit is exhausted, and there

will be no additional funds added for the remainder of the coverage term, an RRE must submit an appropriate termination date. That termination date must reflect either the date coverage was canceled or the date upon which funds were exhausted.

If and when funds are renewed for the following annual coverage period, the RRE should submit a new add record reflecting the effective date of that current coverage period. However, if reportable HRA coverage continues from year to year and the benefit is never completely exhausted, the originally reported open-ended coverage period should simply remain. In other words, there's no need for an RRE to send an update transaction with the termination date indicating the end of an annual coverage period followed by an add transaction reflecting a new effective date of the current coverage period. The original open-ended record may simply remain with the initial coverage effective date.

Finally, as Section 111 reporting is performed on a quarterly basis, there may be times when an HRA coverage terminates or exhausts long before the RRE's next scheduled submission periods. If necessary, in such instances, it is possible for an RRE to request that the HRA record be closed with the termination date by contacting the COBC call center at 800-999-111-8. Next, I'd like to make mention – excuse me. Next, I'd like to make mention of some issues we've noted with the TIN indicator Field 8 within the TIN reference file.

One of the values which an RRE may utilize when populating this field within their TIN reference files submission is in F, as in Frank, which is intended to indicate TIN entry for a federal employer. We have found a significant number of TIN entries being submitted utilizing this federal employer TIN indicator for TIN (injuries) which we're quite certain are not actually federal employers. Please note that it's important for this flag not to be misused. An F value populated within Field 8 of the TIN reference input file must only be used when the TIN entry is for federal – for a federal employer.

The next announcement is in regards to the annual profile report recertification process. Some of you may already be aware we encountered

some problems with their profile recertification process earlier this year. And subsequently the process have been placed on hold. The issues experienced previously have now been resolved and we expect to resume recertifications shortly. That being the case, we want to provide you with a bit of advance notice. Our tentative date for resumption of the profile recertification process is currently September 1st.

So, you may begin receiving recertification request as of September 1st but it could take up to a year before you even you receive your recerts. If you don't receive your recertification in September, that's not because there's something wrong. You just need to wait until you actually receive the recert request via e-mail. This should go to both the authorized (inaudible) account manager. Finally, one again, I'd like to take few moments to remind everyone of the optional unsolicited MSP response file process. Excuse me. Excuse me.

OK. The COBC collects coverage data from numerous sources. That being the case, there will be occasions where records submitted via Section 111 may be updated with information coming from somewhere other than Section 111 file submission. Prior to the implementation of the unsolicited response process, the Section 111 RRE would have had no way of knowing the changes remain to the data which they had previously reported.

Now, an RRE has the option to receive the unsolicited response file which will tell them if a record which they have submitted has been updated or deleted. The unsolicited response files are generated monthly on the second Sunday of the month. File will contain a response for each record updated or deleted by another source during the timeframe since the generation of the last unsolicited file.

Each response record will contain all of the data elements as they presently reflect on Medicare's database. In addition to this, the response will indicate the type of entity from which the information had been received. And when available, the name of the updating entity along with the general reason for the update will also be provided. Maintaining the data provided via the unsolicited response file in conjunction with the data from the standard MSP

response file will provide the RRE with the clearest picture of exactly what covers data Medicare as on file where they're insured (inaudible) the present.

Situations where updates being received by alternate sources may appear be in conflict with their own data. The unsolicited response will help the RRE determine where the conflicting information is resonating from. Although not required to do so, RREs are encouraged to use this information to investigate and rectify discrepancies with beneficiaries and employer groups.

Another significant benefit of the unsolicited MSP response file is for any record on which the RRE receives an unsolicited response. The RRE may send a hierarchy override code on their subsequent quarterly MSP file without first having received a hierarchy rejects code on a prior MSP response file. However, before doing so, the RRE should research to ensure that their information is accurate in instances where there appears to be a conflict. An RRE that does not participate in the unsolicited response process first have to submit enough data on their quarterly submission, wait for a response with a hierarchy reject and then resubmit an update with a hierarchy override code on their next quarterly file.

Participation in the unsolicited response process would allow for the RRE to rectify any possible discrepancies much more expediently as opposed to having to wait an entire additional quarter to do so. The further information of RRE unsolicited MSP response file process, please refer to section 7.2.10 (inaudible) with an concurrent GHP use guide – excuse me.

There have been relatively GHP questions received via the CMS resource mailbox since the last town hall taken place back in March. The one question that we did receive ties in well the information just provided regarding the unsolicited response process and hierarchy overrides. Individual who had written in was requesting clarification regarding the SPH0 hierarchy area code. SPH0 is the area code that is generated when an RRE tends to update or delete a GHP coverage record. We should last going to update it by a higher ranking entity on the hierarchy tier.

The question was regarding what action should be taken after an RRE has received the aforementioned SPH0 error and it read as follows. My understanding of the documentation is the RRE needs to verify their information to what the COBC already has and override as necessary. Does that sound correct? If yes, the response file we received does not show what the COBC has on record in what information we need to verify and override as necessary. Is the response files suppose to show that information, or do we need to contact the COBC each time we receive this error?

OK, so first let me start by saying that it isn't necessarily expected that the RRE verify their information against what the COBC presently has on file. The expectation is that the RRE will verify that the information they had submitted is accurate to the best of their ability. If the RRE confirms that the information previously rejected with the SPH0 error is accurate, then it would be appropriate for them to submit that information on the following quarterly file submission with a hierarchy override code at the HB populated in field 33. That would then allow for their data to overlay or update the information currently on file at the COBC.

However, that said the aforementioned unsolicited MSP response file process would actually allow the RRE to discern what data the COBC has on file at present and would actually make it possible for the IRE to compare their own data with the COBCs as it been suggested within the individual's question.

Also, it's noted previously would allow the RRE to submit an override code without first having to submit their data and wait for that SPH0 rejection. So while it isn't required that the RRE receiving the SPH0 hierarchy rejection error compare their data with the COBCs before submitting a hierarchy override, it would often be possible for them to just (inaudible) if they were unsolicited MSP response process participant.

Please note, excuse me, that this is the manner in which an RRE may look to compare their own data with COBCs as opposed to reaching out to the COBC directly every time they receive an SPH0 hierarchy rejection. Not appropriate for an RRE to call the COBC and request information on every SPH0 hierarchy error code they might receive. So people – I know you hear us talk

about this a lot, try to convince you to sign up for the unsolicited response process. It really does you no harm to sign up. All they were doing is getting you back data, it might be useful to you. All you have to do is be prepared to receive a file from us containing that data.

The follow up receiving that data is not required. Even if you don't have the ability to immediately implement a system process, you automate the response file processing, you can still receive that data and if you had, for instance, an example where you received an SPH0, you can go back and even manually look through that unsolicited response file and compare the data that the COBC has on file with what you have and know whether or not it's even something that you need to submit the hierarchy override on.

In many cases, you might actually find that the information that the COBC has on file at present is just the update that you were attempting to apply and that you don't even need to follow up further. So it's – it does you no harm to sign up. You can do so via the COB secure website, Section 111 COBC website or you can contact your (EDI) representative and they can assist you in – signing up for that process.

With that, I'll turn it back over to John.

John Albert: Thanks, Jeremy. And from CMS perspective as well, we strongly encourage folks to sign up a new – that unsolicited response file process. It goes a long way towards speeding up the (inaudible) resolution between the different submitters or sources of the data that we have, which in the end only helps everyone including the beneficiary. Barbara Wright wanted to talk briefly regarding a question related to the SMART Act.

Barbara Wright: Thanks, John. We actually received a couple of questions. They were asking about whether or not requirements under the SMART Act that has to do with the monetary penalties had been finalized and where we're going to publish that information also about (achieve) this indicated in the SMART Act regarding the use of social security numbers in terms of reporting. Basically, SMART Act questions are generally outside the scope of this call. But even if they weren't, what I want to make sure everybody understands is we cannot

provide specific information on policy changes or regulations that are still under discussion.

With respect to the changes on double money penalties, there – the act does require an advanced notice of proposed rulemaking, an ANPRM. And that ANPRM is listed on the unified regulatory agenda. The anticipated date right now for publication of that ANPRM is September of this year. I would repeat that's anticipated date, we don't have an actual publication date at this time. So, you may want to keep watch out for the (several) register because the ANPRM is specifically soliciting input from the public on the questions asked in that ANPRM. So, keep an eye out for that.

With regards to the social security numbers, we don't have anything that we can report or tell you about any current process to accommodate the SMART Act. Know that the agency is working to implement everything they're required to do under the SMART Act. That's it.

John Albert: OK. All right, with that operator, we can go straight to the questions.

Operator: At this time, I would like remind everyone, in order to ask a question, press star and the number 1 on your telephone keypad. We'll pause for just a moment to compile a Q&A roster.

And your first question comes from Melissa Murphy from UnitedHealthcare. Your line is open.

Melissa Murphy: Hello, everyone. I want to go back to the discussion of regarding the first of the month terms and how that has been interpreted to indicate that we are not sending the correct date relative to when someone leaves employment. We are at the mercy as commercial carriers of the data we receive from our employers. If our employers tell us someone to coverage ends on the 15th, 30th, 31st or on the first of the month, we have no means of knowing why that coverage terminate, whether it was related to the individual leaving employment or they selected another carrier or their spouse had other coverage or any other reason that I can't think of off the top of my head. In cases of true retirement, yes, we get a retirement date and we would send that to you. That retirement date could be the 15th, 30th, 31st, or the first of the

month. So I'm curious how we are expected to report to you when someone leaves employment, meaning they are no longer actively at work, if our data is coming from employers.

My second question has to do with a beneficiary who may be covered as a legitimate dependent on their spouse's actively working coverage. How would we know that that dependent beneficiary is actively at work or not? In my understanding of Section 111, that is not something that we are required to know because the beneficiary is covered by an actively working individual.

Jeremy Farquhar: It's not the actual covered spouse whose active employment we're concerned with the most. It's the – if the individual to whom the GHP coverage is provided that – that, you know, the actual employee, that individual needs to be actively working. And even if their covered spouse continues to be working, if the individual through whom the coverage its based get – stops working that impact's primacy, not the actual person who's receiving it via their spouse, not their covered – not their active status. So it's a matter of the actual employee through whom coverage is being received. And …

Melissa Murphy: Right. So – but in response to the rather large list, the first of the month terms that I received, we identified some key customers who routinely use first of the month as their termination day. These are part of their insuring rules, the eligibility rules that they send to us. And we have no means of knowing are they terminating this person's coverage on this day.

Jeremy Farquhar: Well, you need …

Melissa Murphy: For what reason? For what reason? We cannot go back and question every employer who terminates a beneficiary to say, "Why did you terminate them?

Jeremy Farquhar: Right.

Melissa Murphy: You know that's an internal practice that would be monstrous to implement.

Jeremy Farquhar: Well, yes. I think what would be more important than going back and driving to question all of the prior, first of the month term dates you received would

be, you know, more effectively, you could do your best to educate the employer about the information that they're providing you in the first place.

You tell them, look, this is what you need to be providing me. If you're giving me the first of the month as a termination date, when the last date of their coverage is the last day of that month or if you're giving us the day after that individual's coverage actually terminated as your termination day rather than the actual last day that they have that coverage, that's wrong, you need to tell us the date that the actual last day that that individual was covered or the last day that they're actively employed.

You need to know both – you know, both of those things are something that you need to collect from your employer groups. And it will come down to the insurers trying to do a better job of it, basically educating their employer groups as to what they should be reporting.

Melissa Murphy: So …

Jeremy Farquhar: Yes.

Melissa Murphy: … so I think, so Jeremy, did I hear you say that we not only are expected to collect when an employer deems it appropriate to end someone's coverage? And again, they can end it on the first of the month. They …

Jeremy Farquhar: They could and – let me just say it before – before you continue. That if the actual coverage – if they have coverage on the first of the month, say, an individual retires and they retire on the first of the month. They could maybe – they retire on a Friday, they work out a full week and Friday is the first of the month and their last day work was Friday. Well that – that first of the month termination date is entirely appropriate. We're not saying that first of the month termination dates are not appropriate.

What we did with our analysis is we found that there were a lot very high volume of first of the month termination dates in some instances and it seems to be indicative that there might be something going on that was a bit array and you know something was not quite right with the data and so we are following up. And if we receive a response back that tells all those first of the

month termination dates were actually accurate termination dates and that's fine. And we're just questioning and looking to ensure that the RREs know the way they should actually be reporting this information and trying to clean up data and moving forward.

Melissa Murphy: Right but you also mentioned you expect us to collect the last date of employment and, you know, we don't always know that information and I don't know if my fellow carriers out there are collecting that information.

Jeremy Farquhar: Well, active employment is what primacy is based on. You need to know the status of active employment. You can't properly report if you don't know …

John Albert: (Inaudible).

Jeremy Farquhar: Yes, it's – that's how MSP is determined, so …

John Albert: And that's long before Section 111, I mean the …

Melissa Murphy: That's right.

John Albert: You know the thing is …

Melissa Murphy: No.

John Albert: … that the wrong date is – if the wrong date is reported, it could impact the beneficiary negatively because if we show, you know, an inappropriate open or close period of the record, that could affect the beneficiary's claims being paid or not paid by the, you know, correct payer as well as the impact the employer and the insurer also in terms of any, you know, corrections that we'd have to make after the fact. But I mean, regardless of 111, I mean, the insurer and the employer are required to follow the MSP rules and that's the data that needs to be reported whether it's 111 or IRS Data Match or anything else.

So if – that's why, I think the best thing is, again, it's just more of an education effort and part of certain particular entities or groups or what not that need to know this. And so his – Jeremy's advice about, you know, performing that type of outreach with your customers is probably the best task to take. But

again, it does have real impact beyond simply – if not just that the data that actually has real impact in terms of the claims processing operation.

Melissa Murphy: And we fully understand that.

John Albert: Right.

Melissa Murphy: However, I do have employers who come to me and say, "I will cover this individual as an active employee until this day, knowing that person is not going to work everyday." And it makes …

John Albert: Yes well they – even if they continue to cover them, it doesn't matter if you continue to cover – that they continue to cover them, it's not going to be as primary. They may say they want to pay primary but under the MSP whereas Medicare is the primary payer once they sever an employment, regardless of whether or not they continue to offer that coverage, you know, through the end of the month or what not, it's the actual termination day that – that drives the MSP or not.

Melissa Murphy: To whom should I refer these employers to insist on – and they're not – they're not many. Because we've had those conversations and the employers feel like "I'm paying the coverage. I'm the paying the claims as primary. So I get to make this decision." So to whom should I refer them?

John Albert: Yes, well, I mean, I guess I would say to the COB contractor in general just because they have the people that can explain the rules, you know, if there's – if there's something that you definitely feel like you need to drag us into, that's fine but again, that really, you know, we don't want to over commit what limited resources we have to basically perform that task that, you know, that employer. There's plenty of materials online available for them to understand the MSP statute.

Now, whether or not they choose to continue to pay primary, it doesn't really matter to us but for our purposes that were driven by the statute, so if some other information comes in – and this is what also can happen. Someone may choose to pay primary for somebody but if Medicare terminates that record correctly, that could also cause problems for the beneficiary, potentially.

Barbara Wright: But I think the other issue in what Jeremy raised is not all of these are situations for someone as choosy to pay primary when they're not really primary. When he mentioned all the ones when the term date is, the first of the month, if you have employers out there where they are actually are covering someone through the last day and are then reporting the termination dates as the first day of the next month, that's just wrong. They're not – they're not doing that because they want to pay primary for an extra day, they're doing it because they apparently think you report the day after it terminates.

So in terms of educational efforts, whether you can issue and alert or anything else and say these are some problems CMS has notified us of. If your coverage actually is through the end of the month, report the last day of the month as the termination date. Do not report the first day of the next month. Give them some of the examples like that so that the ones where they're not making the type of conscious decision you alluded to, whether genuinely making an error that those can get corrected.

John Albert: I mean, the materials and the user guides are, you know.

Female: Originally, that's not the last day of the month …

John Albert: Yes.

Female: … is the day.

John Albert: Yes.

Female: … that they terminate.

John Albert: Yes.

Female: Not the next day.

John Albert: I mean, the reason why this came up is because this issue has caused problems and so our contractors, you know, took a look at this and identified like (Jeremy) said that there were particular, you know, clusters of this occurring which lead us to do an investigation to find out that it looks like in many

cases, these dates are being erroneous they reported in. So that's why, I mean, what drove this is because the date was wrong so we need to get it fixed and, you know, that's why we are bringing this up. So, it's, you know.

Barbara Wright: It is quite possible and probable in many cases that the employers aren't really reading the GHP user guides. Their – you're the RRE as the insurer or the TPA or whatever it maybe in a particular case but – so they're relying on what you tell them. So to the extent you can alert them to issues we've identified as potential errors, you're educating them to give you better information.

John Albert: I mean if you have information that an employer is willingly not providing the correct dates to you then, yes, I mean, you can definitely contact us and we can, you know, reach our directly to that employer. We do it all the time where there's like this, you know, willing violations of what should be done, I mean, we can help you with that, for sure.

Jeremy Farquhar: And Melissa, if you want to talk about this more later, I mean, if there's anything that you feel like to discuss whether, you know, I can – I can point you towards anything that might be helpful as far as information that you can share with people. I can dig around a little bit afterwards and you can touch base with me and I can – I can assist.

The new GHP user guide does have additional clarification as I think I mentioned towards the beginning of the call regarding the reporting and termination dates. I don't know if that would be helpful for you at all. You could point them and you tell them, "Look, this is yours. The documentation, this is how we need to report this information to Medicare. This is why we need you to give us this information and it is an official document," I mean, perhaps, that'll be helpful.

John Albert: OK.

Operator: Our next question comes from (Janice Opila) from Dean Health Plan. Your line is open.

(Janice Opila): Thank you. I would like to talk about the SPH0 error message again. I just have – on my response file that I received, there is an MSP effective date and

an MSP end date that does come back on the MSP response file. Now, my SPH0s basically are all my retirees who have just moved to the retiree segment. If I see that the term date and the MSP end date is the same date that I just sent, must I override by SPH0 error code?

Jeremy Farquhar: No, no. I mean that the date the – the date that you see in the MSP termination date field is typically the termination date that would have been reported by the Section 111 RRE. It's either, it's – what you see there is either going to be as a result if something that was submitted by either your entity as a termination date or it's going to be maybe possibly a case where their entitlement had terminated for some reason. If they maybe they are disability entitled or ESRD, entitled individual – their entitlement actually terminated, that's – that day and you can see that date plugged in there if it doesn't coincide with what you have submitted.

But, you know, I don't believe that that date should be populated if your record is rejected with the information you submitted. That's a little strange if – so I'm not sure what – this situation you seem to be referencing, I'm not sure it may entirely make sense to me, that you'd be seeing that. But I have to take a look. If you have some examples and you'd like to contact me directly and have me take a look, I could probably give you some better feedback. And my – this is Jeremy Farquhar and my contact information is in the user guide under the escalation procedure. You can call me, or shoot me an e-mail whatever you like and I can discuss further with you.

(Janice Opila): OK. OK, the only time I put in override is when the dates in the MSP effective and end date don't match what I sent you, then I do research and then I sent and override if my info is correct.

Jeremy Farquhar: And that would seem to be an appropriate course of action. So …

(Janice Opila): OK.

Jeremy Farquhar: … that's fine. I think what you're doing is – we're not, you know, that's appropriate.

(Janice Opila): OK. Thank you very much.

Jeremy Farquhar: OK.

Operator: Your next question comes from the line of (Mario Sturino). Your line is open from Health Care Service.

(Mario Sturino). Your line is open.

Your next question comes from (Andrea Flaherty) from Unite HERE Health. Your line is open.

(Andrea Flaherty): Hi. Yes, I wanted to follow up on that first question regarding the termination date. We are a multi-employer plan. Unlike the first caller, we only get periods of eligibility. We don't have any information regarding employment date. What is very common for our fund is that individuals will be hired and then they have to wait a period of one, two or three months before getting eligibility. And then once the employment ends, then they get additional periods of eligibility after that. And so for our effective dates, we've been reporting the effective dates of eligibility because that was based on their active work status, that corresponding eligibility period is. And what we're understanding today is that that's not completely accurate. It's that that effective date, the end date should be the last date of their employment.

Jeremy Farquhar: Well, it depends. It's either they – the last date of their active employment or the date that the coverage terminated, whichever came first. You know, coverage could terminate and they could continue to, you know, they could decide that they no longer want to continue their coverage, terminate their coverage and still be actively employed, that's possible. That probably doesn't happen all that frequently but it may.

And when that happens, then you should send us the coverage termination date of that if they're actually working. Otherwise, the date that active employment terminates is the date that we need, because that is how primacy is determined. So if you're not receiving that information from these employer groups then you need to start soliciting that.

(Andrea Flaherty): Very good, thank you.

Operator: And again, if you'd like to ask to a question, press star 1 on your telephone keypad.

Your next question comes from the line of Tonya Lee from Blue Cross Blue Shield. Your line is open.

Tonya Lee: OK, we've got a question about collecting the data, you know, currently we're not collecting the data of the last day of work. Our groups are going to look to us for guidance on how to define that. And we're wondering, you know, how are we going to instruct them in what they define as actively at work. Is it the last day they were physically working? If they had PTO or paid time off time accrued, that they're going to pay those people? Does it start at the end of that? If they go on family medical leave but don't return? Is it reported as the date they notified that they're not to return or they failed to return, or when – how do you define last day of work? Because they're going to ask us to provide that guidance so we don't have to report that.

And then also, if we begin to collect this data going forward, what is the expectation about terms that have occurred in that past and prior to us beginning to collect this data because (inaudible) like the other question, how do you go back and ask them when – what day they actually was their last day of work previously on a terminated contract already, and what's the expectation reporting that going forward?

John Albert: I guess, and this is John, I mean, the last day of work is I guess that's – that needs to be pushed out a little bit in terms of, you know, there are situations where people, for example, are seasonal workers or they, you know, essentially they retain employment rights with the company, you know. They may be off (for long) or let's say or on FMLA, I mean, they are still employed with the company.

So, you know, the MSP statute would still apply in the terms of being secondary to the private coverage. I mean, it's not just simply when someone quit work, I mean, there's a bunch of different things that go into that. So …

Female: (Inaudible).

John Albert: You had kind of lot of questions there regarding, you know, what is current employment. And at the – Jeremy, the CBTs that we have out there, don't we have a CBT that talks about that kind of that, you know, deals with the working age roles and things like that?

Jeremy Farquhar: I believe that we do but I'm – I, you know, I couldn't point you towards the specific CBT office out in my head. I believe that it is coverage or we did have something of that nature. So it's something that we could follow up upon afterwards. You know, I can – into it, and you can touch base with me offline and I can – I give – you know, I can locate that and point you on the right direction.

Barbara Wright: Also Jeremy, in response to the last person that was asking about some of those how would they know and they talked about being a multi-employer plan, we missed part of your answer here and to the extent it did not take into account the concept of hours bank coverage. You may or may not need to modify your answer, we don't know. So if you may need some follow up on that as well.

Jeremy Farquhar: Yes. I mean, I – all my answer was basically just the date they needed it to be able to solicit the information that's to when active employment terminated towards the employer groups. So I mean I don't know of the hours bank.

Barbara Wright: OK, multi – multiple multi-employer plans, some of them at least, if not, a large percentage of them have a concept of hours bank coverage, and those rules are a little bit different. And we can look into that more to make sure our coverage addresses that adequately. But their people are earning future coverage based on current employment. So that's a little bit different than the typical employer where you get coverage at the exact same time that you're currently employed. But the hours bank is based upon a current employment concept. So we'll look into what is in the user guide or anything on that and get back to everyone. But I didn't want to alert people that there is some difference there.

Operator: Your next question come from the line of (Mario Sturino) from Health Care Services. Your line is open.

(Mario Sturino): Hi, thanks. My question pertains to, whether or not an employer who's under 20 employees can contribute to an actively working individual's Medigap or (MEDCAP) policy, or can they offer it since they're under 20?

Barbara Wright: You would be sponsoring or contributing to group health plan coverage but the MSP rules only apply if you meet the employer size requirement. If you're not talking about a multiple multi-employer plan and if you're below the threshold for employees, the group health plan coverage that you're providing is not subject to the MSP rules.

(Mario Sturino): And so they would be able to offer a Medigap or (MEDCAP) policy because they're not subject to any MSP rule.

John Albert: Can you hold on for just second?

(Mario Sturino): Yes.

Barbara Wright: OK, two things. First of all, for ESRD Medicare coverage employer size if they're relevant. So if you're doing that, you have an employee with ESRD, you've got an issue with the MSP rules, yes, you would be primary for the 30-month coordination advantage period. Otherwise, if we're talking only GHP, what you're describing is you would be sponsoring or contributing to what would be considered a group health plan, but as long as the working agent or working disabled rule don't apply to you because of your employer size, then we don't care whether you're calling at the supplemental policy or what you're calling it, it would be secondary to it.

(Mario Sturino): And then – so if that's the case, you know, what happens when – if an individual, if the company goes over the (pay for) working age 20 and 20s in the middle of the year and now they're subject to MSP policy. What's the guidance that COBC provide in – I guess changing that individual's policy mid year.

Barbara Wright: We don't control whether you change it or what – how it's handled with the insured, but whatever policy you're providing becomes primary. And if, I'm assuming doing that you didn't have 20 in the prior year.

(Mario Sturino): Correct.

Barbara Wright: But I mean …

(Mario Sturino): And so, mid-way through the year, they now – can the employer no longer contribute to this Medigap policy through for subject, through MSP (law) now?

Barbara Wright: Well, first of all, under the GHP rules, you're getting into a lot of technicalities with what you would specifically provide. If you were providing that only to a beneficiary, your – you would have been a violation in general because you can't treat Medicare beneficiaries differently, you can't take Medicare into account. I mean, if you're talking about, you provide for all employees this type of policy that you're calling supplement and mid-way during a year, you have – you meet the 20 employees thresholds for the number of – for the 20 weeks at any time, then you're becoming primary for everyone who is the Medicare beneficiary at that point if they sit in the working age.

And, you know, the same thing, depending on how many you've got. If you went it from ten to 100, then you'll be looking at the working disabled as well. We can't analyze over this boundary or what would happen in every single circumstance. The general concept is, hey, when you're not subject to the MSP rules for GHP, then you're not subject to them, and we're not controlling what type of policy you're colliding. But when you're subject to the rules, you're subject to the rules. And GHP fortunately, depending on how you're looking at it, employer size is not a consideration.

(Mario Sturino): What do you mean it's not a consideration?

Barbara Wright: The ESRD rules will apply no matter what size the employer is.

(Mario Sturino): Yes. And that – so for ESRD, you obviously couldn't in the coordination period offers a supplemental policy. But, however, if it's an employer is under 20, they could offer supplemental policy because they're not subject to GHP rules or an employer could offer a Medicare …

Barbara Wright: ESRD is a type of GHP. Yes, that – for Group Health Plan coverage, you're talking about working age, disabled, or ESRD.

Male: Great. That's, right.

(Mario Sturino): How is ESRD considered a group health plan?

John Albert: It's covered under – it's coverage paid, paid by your Group Health Plan for those medical …

Barbara Wright: We're talking about the basis of Medicare entitlement.

(Mario Sturino): Yes. So …

Barbara Wright: For GHP coverage for which Medicare is secondary under circumstances. The circumstances for ESRD don't take into account employer size. Doesn't matter how employee – the circumstances for working disabled, they have 100 employee issue. The circumstances for working aged have the 20 employee.

(Mario Sturino): Yes, I understand that. And s, what I'm saying is specifically if we can keep into contact to working age, an employer, if you're under 20 is not subject to working age, I guess GHP, MSP (lot) or regulation, and therefore, if they would be allowed to offer a Medicare supplement policy.

Male: Hold on just a second.

Hi, we're back. I mean, I guess in a nutshell, I mean if the MSP rules don't apply, then they don't apply. So you do what you will, but I guess if someone here mentioned that, you know, if you think you might be going over 20 pretty soon, you might want to think about that. So but, yes, I mean you can do that. If the MSP rules don't apply they don't apply. So offer what you will.

(Mario Sturino): OK. Is there's somebody I can just contact for the situation maybe on this call and that I could better discuss this with?

Barbara Wright: Jeremy, do you want (to see of) that if they call you and you can patch us in if you need to?

Jeremy Farquhar : Yes, sure.

John Albert: Yes, you could set something up.

(Mario Sturino): Thank you, Jeremy, I appreciate it.

Operator: And the next question comes from (Angela Bridges) from WellPoint. Your line is open.

(Angela Bridges): Hi. Yes. I heard earlier in the first question and I just want to make sure that I heard it correctly that it was stated that it's a – the beneficiary is covered under their spouse and the beneficiary is not working but the spouse is working and that would not impact the beneficiary's primacy rules, is that correct?

Male: That's correct.

Barbara Wright: That's pretty awesome, actually.

Male: No, just the opposite. If the coverage is through somebody who's working, then Medicare a secondary, in a simple answer

(Angela Bridges): OK. Yes, OK. If that's what we thought …

Male: If here's the Medicare beneficiary and they are covered via family policy through their working spouse then, you know, assuming of the size rules – I mean Medicare is secondary.

Barbara Wright: We're looking at the current employment status of the subscriber.

Male: Yes.

Barbara Wright: Not of dependence. Think about the fact that often the reason you have a Medicare beneficiary who's a spouse is because they're disabled. We know those people aren't working, if they're getting social security disability. The whole issue is whether or not they're getting primary coverage through current employment of the subscriber, does that help?

(Angela Bridges): Yes. That is our understanding as well. So I just – thank you for confirming that.

Male: Sorry, if we confused.

Operator: And your next question comes from Tonya Lee from Blue Cross Blue Shield. Your line is open.

Tonya Lee: We are wondering – what the expectation is to show due diligence if we begin to notify our group since we're at the mercy of the group to report the last day of work to us. What is necessary to show our due diligence that way we've attempted to collect that information, which we may or may not always receive from them.

Jeremy Farquhar: Well, I mean, again, as Barbara mentioned, there is an ANPRM coming out on the federal register that will, you know, solicit that input from the public which will all go into formulating, you know, a civil monetary penalty. But, again, I mean, due diligence is keeping a record of what you did to, you know, keep the information. I mean, we can't define that for you it's, you know, it's an audit trail in which you have to establish.

So when everybody, organizations and systems and all that are different, but I mean basically if somebody came to you and said, you know, "Hey, you didn't report this, and you can show that we attempted to then, you know, basically kind of what we're looking for." But until the ANPRM and the comments and whatever come out that we really can't provide a lot of comment on that anyway. But I mean we've always said that, you know, we expect people to document and, you know, for their own protection to make sure that they document their attempt to get the information.

Barbara Wright: You also need to look at whether you're doing any analysis or review of the data you're receiving. As CMS has told you, we've identified a problem with how termination dates are being reported. And these are some of the issues then it's presumably behooved you to look at whether your data is showing that pattern. And if it is, do some further – either education and or investigation to determine if you have that problem with your plan.

Male: If we could just ask one additional question. What updates in the manual was dated 7/19 – what, if any, requirements are there as far as providing these two – this additional date retroactively?

Male: Additional what? I'm sorry, what additional date (inaudible).

Male: Via last (set) work date.

Jeremy Farquhar: If you have knowledge that the information was incorrect, you need to update it. That includes past information submitted by you on your 111 report.

Barbara Wright: But you need to look at – can we – we're going to go on mute just a second.

We've been talking back and forth and I want Jeremy to chime in here, too. We keep having the phrase raised last day at work. And Jeremy, unless those of these here are incorrect, we need to make it clear that we're talking about the last day of current employment. For example, if someone is employed and they're either going to leave their job, quit or they're going to retire, either one, let's say. But they have accrued vacation leave. So they're last physically at work on the 21st but their employment ends on the 28th, it would be the 28th that's reported.

So let's not get too caught up in the concept of last day at work. We were looking at the last date of current employment as compared to when the coverage terminate. If the last day of current employment terminates prior to the coverage, then report the last day of current employment. If the coverage terminates prior to the last day of current employment, then you're going to report the date the coverage terminated.

Would you say that's a fair statement, Jeremy.

Jeremy Farquhar: Yes.

John Albert: OK.

Male: Fair enough, I'm sorry for using the incorrect term. I appreciate that clarification. My question was more to do with this is retroactively, this being policy and updated in the manual as of 7/19. So the information (earlier)

reported for years prior to them, you know, what action are you suppose to take on that information?

Barbara Wright: Well first of all, to the extent there was any change in the manual that address this specifically, it was an update potentially for further clarification. The rules have always been there. We've always said you have to report the last day of current employment or, you know, the termination of coverage, which ever is earlier. But in discovering – in analyzing data here and determining that we had what appeared to be at least in different – for different RREs, the pattern of an anomalous termination date, we've felt we shouldn't make it even more explicit.

As always, if you do any outreach and the result of that is, if you go out to – if you look at your own data and you've got almost exclusively first of the month termination, you probably should be doing some inquiry as to why. And if that result in some revised information being furnished to you by the employer, then you should update your reporting. If they confirm like, oh no, we always provide coverage one day after they've left. You know, not that they're reporting it that way, but that, hey, if we fire someone on the 31st, they always got coverage for the 1st and the reporting is being done correctly, then you're fine. But if they tell you, no we've been making this error, then presumably you should be asking them to correct their records and give you the updated data so that you can update your reporting.

Male: OK, thank you.

Operator: We have no further questions in queue. I'll turn the call back to the presenters.

John Albert: OK. Well, that was a fairly short call. Looks like we have some topics that we might want to do a little additional outreach on just to help people understand a little better based on the questions that we got today. Thank everyone for their participation. Stay tuned to the Section 111 website for future calls.

And with that, thank you very much everyone.

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

END