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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
September 7, 2011
1:00 p.m. ET

Operator: Good afternoon, John Albert will now introduce the call.

John Albert: Thank you operator. Good afternoon everyone for the record today is Wednesday, September 7th and this is one of many ongoing, continuing conversations we are having with (Section 111) submitters. This call in particular was setup to discuss HRA, GHP issues. Again this call again we are asking that this call we invited HRA participants to this call to discuss issues specifically related to HRAs and the caller in for the next two hours. As I always say on these calls there are times we may say things or say things that do not think up with what is in the official user guide and where that is the case. The written materials and the user guide and active alerts would take priority over anything that we say in terms of official CMS guidance or instruction.

There are times when we contradict the instructions we don't mean to but there is lot of material and sometimes it happens. We are going to open up we have a somewhat more limited staff today, number of staffers here today there is (Bill Decker) is going to provide some information, we also have on the line Jeremy (inaudible) and (Bill Forbes) from the COBC, they can help with more technical questions related to the data submission process as we -- unless we get through the presentation by Bill we are going to open up the line to questions and answers.

We ask that folks identify who they are, who they are with and if out of consideration for other participants they could limit their questions to one and

one follow up and then get back in the beginning of the queue so that there are people that can have a chance to talk on the microphone.

With that I guess I will turn it over to Bill who will present and then we will get into Q&A.

(Bill Decker): Thank you very much. Hi, I am (Bill Decker), I am with CMS here in Baltimore, we are having this call today to go over HRA reporting under (Section 111). I am going to actually give an overview of both what MSP reporting is, what (Section 111) reporting is and what we believe should be the responsibility of HRAs in that reporting and that some of it will be for some of you at least pretty entry level stuff but it's clear from a lot of the questions that we get and a lot of the information that comes into us that there is some less than complete understanding let me put it that way what HRA responsibilities are under (Section 111).

So, I am going to start from the top and sort of work through the general landscape of HRA reporting and then you will have plenty of time to ask us questions about any of this material. First of all Medicare secondary payers MSP what is that? That is a response to a federal law that was passed in 1980 in fact that says that under certain circumstances Group Health Plan Insurance Coverage is to pay primary to Medicare coverage.

Group Health Plan Insurance Coverage weigh typically reduced to just GHP coverage and it works like this, if a Medicare beneficiary is actively working or an employer or a Medicare beneficiary is the dependent of an active worker for an employer and the employer offers all workers group health plan insurance coverage Group Health Plan Coverage, GHP Coverage and those Medicare beneficiaries accept that GHP Coverage from the employer, in that situation the employer based GHP Insurance Coverage is primary to Medicare and we expect the GHP Coverage to pay a covered person healthcare bills before Medicare would be expected to pay.

That’s crucial important to understand that if it's GHP Coverage it is considered primary to Medicare and under those circumstances we would the GHP Coverage to A, before Medicare does because that’s what the law says.

The question for HRA people, administrators, folks who offer it to employers is does that make me primary to Medicare if I am offering GHP Coverage to employed individuals or Medicare beneficiaries who are dependent of employed individuals, the answer is yes.

You’re in HRA, you are Group Health Plan Insurance Coverage under the law, consequently the coverage, the benefit that you provide to a covered individual under the law is primary to Medicare. What happens is frequently that the Medicare beneficiary goes to a provider of services and the provider will bill the insurance that the beneficiary has that is GHP Insurance Coverage first because the providers are told to do that and they know basically to do that.

If that GHP Insurance is in HRA they will bill the HRA first, they are not going to circle back to that point a little bit, billing the HRA is the first point of difference between an HRA coverage generally speaking an ordinary or a standard GHP Coverage. But the provider will still seek payment through the HRA first.

If the HRA does not provide the reimbursement to the provider either directly or as it's more common through the beneficiary him or herself then the provider is blessed with a decision about what to do next, who should that provider bill if the HRA does not pay.

Unfortunately in a lot of cases the default for the provider is I will bill the beneficiary and the provider should be seeking any other Group Health Plan Insurance Coverage that exists to bill first and if that doesn’t, if there is no other Group Health Plan Insurance to build the provider can bill Medicare as a secondary payer.

There are a lot of options for providers to take when an HRA will not pay providers bill or the funds in an HRA aren't used to pay providers pay but the first thing we want to impression up all you folks out there on this call today is that a lot of the issues that have risen with HRA reporting as GHP and particularly under (Section 111) reporting is that providers aren't examining all the options that they have and one of the things we hear that CMS is doing is doing extensive outreach to providers now to inform them of what they might be considering doing and in case where a Medicare beneficiary has an HRA but the HRA cannot pay the providers bill, that's the first thing.

The second thing that we are doing here at CMS is examining all the ways that we have set up already for HRAs to interact with CMS as those of you who have signed up for (Section 111) reporting know once you get your RRE status and start making reports to CMS specifically sending in data to our coordination of benefits contract or COVC once the COVC begins to get your input file what happens next is that a notification of your status as a primary GHP Insurer is placed on one of our major data management system and that data management system will show that there is primary coverage for that beneficiary that should be paying instead of Medicare as the first payer.

When a provider bills us the provider sends the bill to another contractor a Medicare administrative contractor it's called a Medicare (MAC), the (MAC) can look up the beneficiaries record and it will see that there is primary GHP Coverage ahead of Medicare.

If that primary GHP Coverage does not pay or it starts backtrack a little bit, if there is primary GHP Coverage on our records and we get a bill from a provider we tell the provider that there is primary GHP Coverage and Medicare will not pay. That's when the provider then has to seek other payment options if they bill us primary, that's right.

Male: And we are not.

(Bill Decker): And we are not that's correct. So that's the situation that all of the GHP Insurers find themselves in, if you are a (inaudible) shield plan or (inaudible) plan or one of the (inaudible) plans or any of the other large sort of what we call more generally standard GHP Insurers that's generally not an issue. But it can be an issue with HRA reporting because HRA there are two very distinctively different things that happen with HRA.

First of all most of you know that HRAs are do not have the same amount of money available to pay provider bills as to understand insurance coverage's that is always a problem because an HRA can exhaust it's benefit coverage before it's term of benefit coverage is actually up then it won't pay and then we have a provider going your insurance didn't pay.

Saying that to a Medicare beneficiary, the second different issue with HRA is that providers generally speaking don't actually bill an insurance company if the coverage is HRA coverage, they are actually asking for cash from a beneficiary or more likely the beneficiary is paying for the providers services with something like of Visa or MasterCard or a debit card of some nature.

In other words it looks to a provider in much more like a cash transaction involving the beneficiary that it does a transaction been sent to a major insurance company and having the insured provider with a check.

That has also generated some complicating issues in the way our beneficiaries and the HRA industry would interact with each other. That's the general groundwork, most of you know that we discussed HRA reporting in our GHP user guide starting on page 66, most of you should also know that you could find out also in that user guide much more closer to the front who should report what the general process of reporting is and why is we do all this. If those of you are on the call haven't reviewed all that material yet it will be useful if you did but I am pretty sure that probably all of you have.

We did get a questions in specific to HRA reporting and a lot of the information I have just given you actually answered most of those questions. We do have some questions that we can answer that came into us that I haven't addressed yet. The first is can you register as an RRE that's a response of the reporting entity and in advance or do you have to wait until you're administrating GHP Insurance Coverage that requires reporting. You can register in advance and probably should register in advance get ready to report when you know you should be reporting.

We had a question about finder file, can – when they should be sent, whenever you want to send them it's fine they can be sent in whenever they don't have to be sent in at any particular schedule it's useful if we do work out a schedule but as those of you have already registered interacting with the COBC know you will be available to work with a DDI representative and ED rep at the COBC and get that sort of question answered. Do you if you have nothing to report, do you have to report anything the answer is no you don't have send a blank file you don't have to make any report. If you had been reporting and you are going to skip a reporting period you should report that your EDI rep just so the (COOBC) will know that they should not be looking for an incoming file.

Those were the sort of the general questions that we I didn't cover in the opening remarks and I think I am about done with giving opening remarks and if John you have anything else you want to say or I will ask Bill and Jeremy (inaudible) of COBC if there is anything they would wish to add at this point.

Male: Nothing from our end.

(Bill Decker): OK good.

John Albert: This is John, I mean I will just reiterate again that we understand that while HRAs are considered a form of Group Health Plan Insurance Coverage it's become obvious that not one of our many external partners are familiar with

what HRAs are and how they work and that there have been issues with billing and we are working to address that so we have some ideas that we can't discuss here on this call we have some ideas about things we can do to hopefully improve them learning about HRAs fit into Medicare coordination of benefits and hopefully addressing some of those issues.

Male: Operator you can open up the call now to folks on the line.

Operator: In order to ask a question press star then the number one of your telephone keypad. We will pause for just a moment. Barbara (inaudible) from SunGard. Your line is open.

Female: Hi my question is really about (inaudible) is more technical it's something I can go ahead and ask you or are you going to limit it to HRA only calls?

Male: Well we prefer if it was HRA specific but since you are on the line.

Female: OK I had asked if a mailbox I didn't get a response but this has to do with your changing requirement on the coverage action reporting and we have looked at a couple of ways to handle that, and specifically I am concerned about when we sent you two iterations of coverage if they are (inaudible) and the only difference is they are changing coverage action, so we are trying now to implement that not been an MSP determining field. So we can there are two things we can do, one we can (inaudible) MSP period and sent you an ad and mix them one or the other option is we can just merge the fields together and we would never send you an update for any interim MSP periods we have previously reported. Can you advise us on how we should address that?

Male: It's not entirely clear to me what your scenario so I apologize.

Female: OK someone went from employee only coverage to employee (inaudible) and so we sent you two MSP periods they are contiguous they are like January 1st to May 31st and then June 1 on this open ended.

Male: That's actually appropriate that's fine, that's what you have been doing in the past, you were informed otherwise that you should not be sending separate coverage periods when that occurs?

Female: Only on change of coverage action yes.

Male: No that's actually appropriate, you have a change in coverage action we want to know because that does have an impact you could have a situation where you are reporting a (inaudible) coverage and I believe.

Female: I believe they told us not to do that anymore.

Male: I wasn't aware of that change.

Male: We would like to know what that is because I mean that's one of the big coverage one of the matching criteria so that's one that we definitely want to know differently about it. You can point that to us we would love to see it because it's wrong.

Female: If you want to come on to another caller and I will jump back in the queue and I will find it, would that be all right?

Male: That's fine I mean anyone here has….

Male: Yes that will be fine we can go to another caller and come back when you are…

Female: All right. Thank you.

Operator: (Richard Glads) from Infinite Source. Your line is open.

(Richard Glads): I have two quick questions I guess one question and a follow up question, first of all is there any thought that you would increase the $1000 threshold indexing it to inflation or something like that?

Male: Yes I mean the thresholds are always under consideration so yes.

(Richard Glads): In addition there is a hybrid type of reimbursement plan that really a predecessor to HRAs code of Merck plan I don't know how familiar you maybe with it. It's a medical expense reimbursement plan that had no carry over feature. In essence it has the same characteristics of an HRA just more limited these Merck plans would also be subject to the MSP reporting one thing.

Male: Are these Merck plans strictly employer funded?

(Richard Glads): Yes.

Male: There is no employee funding whatsoever?

(Richard Glads): There is one talking about our -- some of them may not have been.

Male: OK one of the keys for HRA or HRA type reporting is that they have to be entirely employer funded, entirely employer funded yes we don't have any employee contribution because that – turns them to a cafeteria type plan.

(Richard Glads): So in another words rose by any other name rose is still a rose.

Male: Right so that's as much as I can tell you about at this time if you have – did you send that through the mailbox?

(Richard Glads): We did not.

Male: Could you do that for us please?

(Richard Glads): Yes.

Male: And we will take a look at that, that's not a type that I am particularly familiar with.

(Richard Glads): All right.

Male: Yes please to folks on the phone only because we did not receive very many written enquires to the CMS resource mailbox. I can't stress enough that we value that input those kind of questions, so please document those. We are not going to provide necessarily a direct response because between all (Section 111) we have probably 100,000 questions and there is about 20 people around this whole program. But we use that information to formulate new materials and address them on these calls and things like that.

So please send those kinds of things and we appreciate it.

(Richard Glads): Thank you very much.

Male: Next question please.

Operator: (Lauren Cantwell) from Healthcare Services. Your line is open.

(Lauren Cantwell): Hi I just had a question regarding some of the reporting we have for our HRA accounts we do have a few that we provide but we do not provide the medicals so I just want to know I we have any other carriers that are experiencing some of the issue where these HRA individuals are taken in and treated as medical and now they are getting the responses and their providers are getting involved and not really sure where to go from here.

Male: Would you explain to me a little bit about what do you mean by you are not covering medical?

(Lauren Cantwell): Correct. We just provide HRA for some employer groups.

Male: OK. Do you realize that any money that goes into an HRA well maybe you don't, any money that goes into an HRA provided it's entirely by an employer for health reimbursement let payments that the money that the – what that can be used for is not determined not by CMS and even not by the administrator but by the employer for that matter but rather by the IRF.

And it's essentially whatever – well we will get into what it is but basically it's for any kind of healthcare related expenses that the individual has HRA account available to him or her can use it for. It could be in fact for medicals and there wouldn't be any way that I don't think any way that I would know of that an HRA administrator or an employer could prevent it been spent on medicals since that's exactly why it's setup. It may be used for things that are not strictly speaking medicals, but basically HRAs are that the reason why they are considered Group Health Plan Benefit Coverage is because they pay for healthcare.

(Lauren Cantwell): OK.

Male: So your question is a difficult for us to answer because they are in fact for medicals.

Male: Yes and if there are money's available they should primary to Medicare.

Male: Right.

Male: Or where the HRA is through the person's work.

Male: That's why I asked you at the beginning what do you mean – could you explain to me how it is that you would think that they are not been or they are not supposed to be used for medical.

(Lauren Cantwell): Yes that's still what we are kind of looking for on our end from where it's in that regards but as you say I mean HRA they spend wherever so that definitely will be applied to medical?

Male: Yes. That's why it's GHP Coverage. OK?

(Lauren Cantwell): Yes. Thank you.

Male: All right, next question?

Operator: (inaudible) from Solaris Heart. Your line is open.

Female: Hello Bill thanks for all your help, this has been very informative and I have a question I wonder if you would read this with me.

You mentioned you were talking about the coordination benefits and which on the HRA and which member or beneficiary we have HRA but there wasn't any money in the account. So let's assume that there is no money in the account so in that case we could not send a secondary to Medicare because the primary hadn't paid anything the primary paid zero so Medicare is a secondary probably pay zero, is that assumption correct?

(Bill Decker): Now who is the we here?

Female: The provider, if the provider of a physician bills say we rendered medical care to a patient and they have an HRA as primary so the patient had no money in the HRA for their HRA to pay.

So how could the provider, the provider could not bill Medicare as secondary because the HRA had not paid anything primary normally in a zero pay claim Medicare wouldn't pay secondary anything if the primary didn't pay anything.

(Bill Decker): That's not true I mean there are a lot of this I mean if the other payer doesn't pay Medicare essentially calculate this payment based on the fact that there was a zero pay bill by the primary payer.

Female: OK so assume there was a zero pay that's fine, assume there is a zero pay by the primary and Medicare is going to calculate their secondary. How do we get the electronic claim without any primary zero pay to attach, how do we do the EDI aspect?

Male: How do make a secondary claim for payment as you?

Male: I mean the EOB would come back with the explanation of benefit which shows if there was zero payment made by the primary pay.

Female: But remembering your example you said that the primary payer many times we as physicians are used to billing an insurance but in this case the HRA is with the beneficiary in who in a lot of times may pay with the debit card or a credit card or they may make a partial payment or they may pay zero so we are not billing an insurance.

Male: Yes I know I understand that, we understand that right, you got a situation who have a theoretically situation at least in which the Medicare beneficiary who is standing in front of you has no money to pay you.

Female: Right.

Male: There is no money in that HRA account.

Female: Right.

Male: What do you do next…?

Female: Thank you.

Male: My advice there is to ask that person standing in front of you if he or she has any other healthcare insurance.

Female: OK.

Male: Because it's very likely they will have other GHP Insurance for example, it is not particularly common for an individual who is on Medicare to have nothing but HRA coverage.

Female: OK.

Male: Ordinarily some other try for GHP Coverage it happens, believe us it happens.

Female: Sure.

Male: But it's not particularly common and your question for a provider will be who else may I assume that I could bill here.

Female: OK.

Male: In that case you try to find out beneficiary who else I could bill and all that path.

Male: I mean you got to take what we are saying with a little bit of (inaudible) because we are not claims processing experts, I mean we are not involved in claim processing operations we are trying to get that information to the right heads of your chair but again we say about claims processing is adoptable.

Female: Sure.

Male: But at the same time we do know enough that yes I mean zero pay bill I mean that was one of the first things that was readily apparent that you know people were – the providers were coming to Medicare and billing us for primary payment when there was nothing left in the HMO and it shouldn't be doing that and they know that and that's the kind of stuff we are trying to correct now.

This is why I don't know how much we can answer for you on the call but clearly it's an issue and we can hopefully get in contact with the folks to deal

with them more claims processing operation aspects of Medicare to get that question and answer for you.

Female: OK. Thank you so much. That's a big help.

Operator: (Guano Masson) from the Doctor's Clinic. Your line is open.

(Guano Masson): Hi I happen to be one of the people that is covered by an HRA and Medicare and I am still employed. I have no other insurance other than my HRA so what you are telling me is that I have to pay upfront for my services and then try to get it on the backend of Medicare, I don't understand how you can coordinate that benefit and I have kind of worked out a situation let's say I had a service that cost $1500 and I only have $100 in my HRA that's going to leave a balance of $1400 now if Medicare is allowable is only $500 of that what happens to the rest of it, how do you coordinate benefits if it's not an insurance. I don't understand this.

Male: If an HRA first of all if you have an employer based Group Health Plan Coverage and that Group Health Plan Coverage is an HRA regardless of what the amount is that is considered to be primary to Medicare. Yes you have to use that HRA money to pay for your healthcare before Medicare will begin to pay for whatever maybe leftover. Whatever Medicare's payment rules are and here is another area that the folks here in this room don't have any control over whatever payment rules are would apply once Medicare begins to pay but the first payer inline to pay your healthcare bills under those circumstances is your HRA coverage.

The second payer may be Medicare if you have no other GHP that is employer based coverage, it may be some other type of coverage that you have but that's something that would has me determined by in fact other folks who are not here in this room.

Female: So then I could theoretically end up paying more out of pocket because I have an HRA then if I just had Medicare alone.

Male: It's hard to…

Male: Our payment is secondary payer though is also based on what the primary payer paid so I mean there is a lot of calculations that go into that.

Male: I was about to say it's hard for us. We couldn't make a statement like that and have anything to base it on because we don't know what the primary payer pays.

Male: If the primary payer pays like you know basically what the GHP most typically would pay Medicare secondary payment is going to be a small percentage of the total bill but if the primary doesn't pay a lot of it because it's not covered and it isn't covered by Medicare, Medicare is going to probably make a huge secondary payment.

Female: So do you know would Medicare then reduce their payments down to their allowable and would the physician have to accept that allowable if there was say only maybe $10 in the HRA.

Male: Yes unfortunately I don't think any of the people in this room are going to answer that question.

Male: Yes right that's not something that we either know very much about or actually have any control on whatsoever.

Female: You know where I could…

Male: Yes you could send that particular question to our mailbox and we will make sure that it gets answered.

Male: Yes we have some folks in the media organization (inaudible) that will be able to assist.

Male: That's simply something that we don't deal with here at all. We do coordination of benefits rather than who paid what amount, I know it sounds like a big bureaucracy and actually it is.

Female: Yes.

Male: All right.

Male: Yes unfortunately I mean just HRA have been considered Group Health Plans for a long time and unfortunately the lot of the HRAs were setup without taking into consideration the need to coordinate with Medicare for whatever reason and now we have you know this (inaudible) reporting which is driving the reporting and it's data and so in many ways these are the kind of issues that come up that need to be addressed to make sure that every one of the following essentially will be MSP rules that have been on the books for an awful long time. So, you know that's why we want to hear from you guys because we are trying to make sure that all of the players in Medicare and throughout can get the right information to make this implementation as smooth as possible.

Male: Next question please.

Operator: (Tim Peterson) from Diversified Benefit. Your line is open.

(Tim Peterson): Thank you and thanks Bill for having this call on CMS, HRA, MSP reporting. We have talked in the past and I just wanted to bring up a couple of items suggestions that were made for the reporting aspect, we are third party administration firm that is reporting to CMS and participants we have that are in HRA. You currently exclude HRA that have a value of a $1000; question is have you considered raising that to either 500 or $10,000 in terms of the value.

When we talked the last time I thought you had indicated that could be a possibility but I didn't know where you were on that and then I have a couple of follow up questions. Is there anything…

(Tim Peterson): Are you guys considering it?

Male: Yes we are considering it.

Male: We haven't reached a conclusion yet but we are definitely considering it that as one step we could take in addressing some of the issues that have come up with HRA report.

(Tim Peterson): Thank you for doing that would be a big help if you would increase that cap, there is another issue is that if there are either isn't a balance in the HRA or if the HRA was designed to not pay out until the employee reaches the certain level in terms of out of pocket expenses. We are told that we have to report those people but the preference would be not to report them at least until HRA money is available.

Any consideration in the committee or Bill and what you are thinking about there as far as not mandating that we report those even though they might be Medicare eligible.

(Bill Decker): Are you saying that you might have an HRA setup for someone that is not funded yet and would you have to report that HRA?

(Tim Peterson): Correct.

(Bill Decker): And you also are saying that you might have an HRA and even if it is funded may not be into payout until a certain level of medical expense occurs?

(Tim Peterson): Correct until for example if there is a $3000 deductible and may be the employee has to incur the first $1500 and then the next $1500 would be reimbursed through the HRA, the person may have a minimal amount of claims that have come through and have not incurred their portion of the HRA plan design in terms of this design on the deductible and the reimbursement by the HRA yet the HRA would show that there is potentially $1500 is just not available yet to that person.

We are told that through the documentation from CMS that we do need to report them but it would be not appropriate for Medicare and CMS to turn off Medicare benefits because the person has never reached the level of the HRA at that point.

Male: We are going to offline just for about a minute and half here and connect them back on; we are going to put ourselves in queue. We will be right back.

(Tim Peterson): OK.

(Bill Decker): Hi we are back.

(Tim Peterson): OK Bill.

John Albert: Yes this is John, I mean...

(Tim Peterson): Hi John.

John Albert: Again this is very similar from what you saying to just like if they have an HRA but they have also run out of money and the coverage is in effect and the same thing would occur with potentially with a GHP Coverage as well I mean the coverage created the coverage period and that's the reportable information that we need and this would – you know if the HRA didn't pay that would be reflected on the submission to the Medicare in terms of what the primary payer pay just like it would be if they ran out of money.

Male: If they don't have money at all, is there any consideration on allowance to have either do a corrective file or not report them if we hadn't reported them before even if there was an HRA they are eligible for Medicare but they have no money, there is no money in the HRA it wouldn't be appropriate for them to receive a letter from CMS indicating that their Medicare was suspended.

(Tim Peterson): What do you mean Medicare was…

(Bill Decker): Medicare is not suspended if they don't have any money in the HRA. The provider needs to bill Medicare as a secondary payer. I understand what you mean.

Male: OK Bill.

(Bill Decker): What they typically get is some sort of a letter saying from a provider generally speaking Medicare didn't pay me, and Medicare wouldn't pay so pay me but you know our – we look at this from a perspective of this is GHP Coverage. Same rules apply to Blue Cross Shield Coverage. If the coverage is exhausted for some of the benefit coverage is exhausted for some reasons same things would happen.

The enquirer would bill the insurer, the insurer would say sorry we are not paying; the provider at that point would say no bill and send us for secondary coverage.

Male: And they lay in the front end I mean if there was a high deductible GHP Health Coverage that the first bill came in.

Male: Right.

Male: I mean…

(Tim Peterson): If there were some allowance though where we can person a system to either report the person or not and they really become eligible if they first of all if they have money and would be into an HRA pay situation. If they are not in that, in many TPAs feel it wouldn't make sense to be required to report them because the HRA wouldn't pay or likewise if they have exhausted their money since we only report quarterly to CMS they could exhaust their HRA funds the day after we send the file in and now for the next three months they have no money in the HRA as the provider of medical service would receive a letter and the participant would receive a letter from CMS indicating that the TPA is the primary insurance provider and there is no money in the HRA or no money available that why I was just wondering if there would be any allowance in terms of who we report if we could parse that more free wouldn't that be better.

Male: That's why we are looking at the first thing you brought up which was the reporting threshold itself.

(Tim Peterson): OK.

Male: And yes you have got – there is a germ of an idea in what you just said that we have actually discussed here, I am not going to go into it because I don't

want to sow any seeds that may not grow but there is something else that is a tweak we could make to the reporting but we have to examine that. We understand what your basic, what the basic dilemma here is.

(Tim Peterson): OK.

Male: We do want to address it as quickly as we can believe us.

(Tim Peterson): Regarding that Bill in the letter that would be coming to providers of service or to participants, was there any discussion on maybe softening that or changing it to where the TPA like ours here at Diversified Benefit Services, we are not a primary insurance provider.

We administer the HRA but we have never have and never will be in other TPAs are the same but we are not primary insurance yet that the letter that is received by providers of services and participants it indicates from CMS that we are the primary provider of insurance.

Is there a way where we could maybe soften that letter or change it to be a little bit more sensitive to really what the reality of the situation is?

Male: Softening the response we are making to the beneficiaries are they are actually changing the response that come to beneficiaries from providers or from us in these situation. Actually another big issue that's on the plate in front of us.

(Tim Peterson): What is? OK.

Male: I do want to say though I do want to remind TPA administrators that they are in essence insurers is not that you are not an insurer it's just that you are not a standard insurer, providing GHP Coverage as a product to employers and they are purchasing it from you and that what's makes you an insured.

(Tim Peterson): Bill has there been any consideration given what the – some of the issues that have come up and some are fairly major especially for participants and employers, is there any possibility that the reporting requirement could be suspended for a period of time by you or by CMS until some of these issues are clarified and addressed, we are compounding the problem by continuing to report with the situations that we have discussed and I know that you are aware of in the past Bill I just wondered if there was anything been entertained with your group of people at CMS and maybe potentially suspend the reporting by TPAs for a while.

(Bill Decker): Yes that issue has come up also that's all we can say.

Male: Yes we can't divulge like you know what the final is and so – the decision was made by…

(Bill Decker): There is an obvious temporary solution.

(Tim Peterson): I understand I just wanted to get it out there just so that we have talked about it and it would be helpful if you would please consider that.

Male: We are.

(Tim Peterson): All right. Thank you, thanks for setting this up today.

Male: No problem. Thank you.

Male: Operator next question.

Operator: (inaudible) your line is open.

Female: Hi I am back with my (inaudible) question, I did find where I got the information I was basing my question on, in your most recent user guide 3.2 April 20th in your tentative change its Section 7.2.6.1 and the event table and Section 7.6.2.2 were updated to remove the employee coverage selection, (inaudible) of MSP (inaudible) detail record from the criteria for a subsequent update and delete that transaction. These field is not used in making MSP determination and then if you go that section you will see that field is no longer included among the ones that it states are used to determine prior to MSP periods and finally in the record lab itself there is a field of no option.

Male: OK you are right and I think the confusion before was between on my part anyhow I think I thought you were referring the relationship code – they are very similar.

Female: Right, so would you like to revisit my original question on how we might address this at best?

Male: No I think what you were saying previously is that you have been sending separate coverage period every time there was a change to field 19th.

Female: Yes.

Male: And that's not actually problematic as far as you are having done so in the past, if you have numerous records so have been they wouldn't be open obviously you might have to hold a record in that terms but then a new record it was added subsequently. But if you have had numerous coverage period that are continuous and they are accurate, you don't have to worry about going back up there and cleaning up to those old records.

You can leave those alone, those are OK but you don't need to be sending us an update to create you don't need to churn out the old records and re-add a new record whenever there is a change that employee coverage election field.

Female: And I wish it was that simple. Our problem is making this change from considering it a field that required an update to one where you do not want an update where we are not allowed to send an update because we got these things sitting in our history to which comparing against and we do need to get rid of all those – we need to put all those periods together which will cause to get an update on an (inaudible).

We can just make it go away and if something happen to that is to – to one is interim period you will never see an update on it or we can delete them all and re-add them and so we are in sink again but we just because you have taken it from being an MSP disarming field do not, our programming didn't allow for that to happen and we are having trouble making that but we have ways we can do it but we don't want to mess you up when we do that.

Male: Why don't we take this conversation offline and we can chat.

Female: I would love to, I would ask for someone to contact me. How can I make that happen?

Male: OK this is Jeremy (inaudible).

Female: OK.

Male: My information is in the user guide in the section on the escalation procedures?

Female: OK great.

Male: My direct phone number is 646-458-6614 if you want to give me a call.

Female: I would love to do that. Thank you very much.

Male: OK.

Male: Next call operator.

Operator: (Chris Keane) from Benefit Resource. Your line is open.

(Chris Keane): Hi, I was curious if you guys have given any thoughts to providing REEs with robust linked to access to COBC database. Currently we are only able to make changes every three months and especially as an HRA provider we are running in problems where either a retiree was reported incorrectly or terminations that happened immediately after we provide our reporting.

Is there have been any thoughts providing a way for us to go and update or change existing occurrences outside of the quarterly file reporting process?

Male: We have discussed those kinds of ideas but unfortunately we are not able to do that at this point in time. I mean obviously well there is talking about like a one on one direct change or whatever.

I mean that's something that in the future we would like to be able to do more and more of that kind ability to do self-service to your information but right now we are not able to do that and probably it will be quite some time before we can for reasons we can't discuss.

(Chris Keane): OK and I also have one another question concerning the turnaround time for response files. Currently we are waiting about 45 days to receive our files back and we are receiving a lot of talk back from participants where their claims are getting denied before where you are going to wear that, they have been added to your system, is there any way that the turnaround can be shortened considerably?

John Albert: So I assume Jeremy and Bill this might be a situation where a lot of the records successfully posted but we might have some recycling out there which prevents the entire file from going back sooner?

Male: Exactly John, normally the majority of the records will probably process within the first week but then the other ones will recycle in – it does take 45 days and there is not much we can do about that.

(Chris Keane): So essentially what you are saying is unless everything in the record in the file that we send basically add then or delete their updates or whatever, if there is any records that are not adding they are just going to recycle it for next 45 days until the file completes?

Male: Exactly. The problem is that if we were to try and cut you a response file much earlier than that there is a good chance there can be a significant number of records it might be a small percentage wise might not be very large but it could be a significant number of records that are left hanging in the balance and wouldn't have an appropriate disposition to provide for you what you would get back to the 50 disposition code if we were to cut that response by early.

You would never know whether those coverage's had posted successfully or not which is important for you and we don't want to – we want to be able to tell you specifically as possible what we actually did with your data, if we post your records or not and we don't want to send you a response file that has

(inaudible) it doesn't really tell you much of anything so that's the situation that we are in there.

(Chris Keane): And I understand that but I mean we are also required to report all active covered individuals over the age of 45 you know and all likelihood we had a mass majority of those people are not actually Medicare beneficiary.

Male: Well they would be posted to our systems and claims will not be denied.

(Chris Keane): Which is correct but those are the people who are holding up us been able to feel the questions for those people who actually are Medicare beneficiary.

Male: No they are not the ones that would typically hold up the process because if they were, the first thing we do is look to see if they are Medicare beneficiary we are talking about the ones we are we have done a match and we have confirmed that there is a Medicare beneficiary that matches your information and they are trying to post all of the detailed information to our CMS systems and that's usually where you have records that get hung up.

There might be something wrong with a particular field or they run the records to different other routines and things like that so that's what it is. The people that aren't beneficiaries or at least people that we do not identify that's the first step that occurs, that does not take 45 days that's the data file comes in basically.

(Chris Keane): I got you.

Male: And so again and someone pointed we use the (inaudible) file too as well to so that you don't send those people if you don't want.

Male: Sure you can always (enquiry) on people you are not sure of or might want to check out.

Male: Which will make your file a lot smaller because most of the people between 45 and 65 don't have Medicare that's another option if you want but again in terms of – that is not what is holding the response file. It's the one that we have a beneficiary and we have your information but there is something about the information you provided that's not allowing it to pass all of the different routines that run at – that goes either our COB contractor and/or our Medicare common working file.

(Chris Keane): So those generally the people who will come back with the error records in the file, the MSP or whatever.

Male: Yes.

(Chris Keane): OK great. Thank you.

Operator: There are no further questions at this time.

Male: OK. Thank you very much operator. I will talk for about a minute or so just in case anybody else wants to cut in for a one question or so but basically I hope this has been useful for you all. We tried to get the point across here that you really are reporting insurance (inaudible) and that's what is the law says that you have to do and that's what the law has made us help you do and this is a type of coverage that is not particularly easy to cope with because it is of a small dollar amount frequently episodic and as you have heard already on this call a great many people involved in the HRA world really don't even consider it to be insurance half the time.

So, we are working diligently to make some adjustments to the HRA reporting process that we think will be useful and we will get out to you as soon as we can.

Operator if there – is there anybody else in the queue waiting to talk to us?

Operator: I have (Tim Peterson) Diversified Benefit. Your line is open.

(Tim Peterson): OK. Thank you operator. Just I response to that Bill I think that many of us who are TPAs out here feel that HRA is just are not insurance even though that it is funded by the employer and I understand that discussion but for years and handling deductible reimbursement plans or HRA if there were solidified through the Internal Revenue Service and Treasury since the early 2000 this just was not looked as an insurance and they are used as a supplement to traditional insurance. They maybe a form of insurance in some people's minds but I think it's a traditional form of insurance like most primary insurance providers provide with a great deal of money involved in those insurance contracts it's just does not what an HRA is and as a result I think the easiest item or quickest that could provide some immediate relief in CMS would be helpful in that regard would be to raise the cap from the current under a 1000 or up to a 1000 to if you could raise that to at least 5 or 10,000 that would be very helpful in this reporting process.

(Bill Decker): Thank you again for your remarks we do appreciate them and we understand fully where you are coming from too.

(Tim Peterson): Thank you, Bill.

(Bill Decker): You're welcome. Operator, any more questions?

Operator: (Guano Masson) your line is open.

(Guano Masson): I would just like to add a little bit from the physicians' point of view to what the last gentlemen said we are so used to being able to have an actual EOB from an insurance company that makes it simple to coordinate benefits with – this is a nightmare trying to do any kind of COB with a plan that really isn't an insurance company but is just a savings account, so that's my only comment.

(Bill Decker): Thank you. We understand the magnitude of your problem and it is one of the reasons we are working on changing the way looking at least considering changing the way we are doing this reporting.

Operator, any more calls?

Operator: There are no further questions.

(Bill Decker): OK. Thank you very much everybody, John you want to close it off?

John Albert: Yes thanks again for your participation. Again I will remind folks that had questions and were not – you know please document your question to the CMS resource mailbox and especially identify in the subject line that they are HRA related so we can pick them out of the 10s of 1000s of other questions we receive workers comp liability and (inaudible) in particular but the -- again we use that information to guide us and making sure that we are implementing this as efficiently as possible for all of us affected by the MSP statute and the (Section 111) reporting requirements.

Stay tuned for the to the (Section 111) web page for additional information about upcoming conference calls, new user guides et cetera with that thank you very much and if operator if you could stay on the line once you disconnect everyone.

Operator: Absolutely, this concludes today's conference call. You may now disconnect.

END