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SUGGESTED AUDIENCE: Group Health Plan Technical and Policy; Question and Answer Session.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Bill Decker
October 5, 2011
1:00 p.m. ET

Operator: Good afternoon. My name is (Sheila) and I will be your conference operator today. At this time, I would like to welcome everyone to the Group Health Plan Technical and Policy conference call. All lines had 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 one on your telephone keypad. If you would like to withdraw your question please press the pound key. Please limit your question to one question and one follow-up. Thank you. Mr. Bill Decker, you may begin your conference.

Bill Decker: Thank you very much, operator. We appreciate that. Hi, everybody. My name is Bill Decker and I'm with CMS in Baltimore. For the record, today is Wednesday, October 5, 2011. It is 1:00 P.M. Eastern Time.

This is GHP, National Town Hall Teleconference Call. We're going to be discussing your questions today, trying to answer you questions. We are taking questions on both policy and technical issues during today's call.

On the line with me in New York City are Mr. (Jeremy Farquhar) and Mr. (Bill Ford). (Jeremy) and Bill will be making an initial presentation. And then I will follow-up after they have made an initial presentation with short one of my own. And we will then open it up to your questions for the remaining time.

This is a two-hour national call. And we'll take questions until you're all done or the two hours are up, one or the other.

With that said, I do want to point out to everyone that this is a live call. You're being recorded. I also want to point out to everyone that as we always say, what we say on this call is what we are based upon what the official information is posted on the Section 111 Web site.

What we say here may conflict with something that is official and posted on the Web site. The official postings on the Web site are the official rules and the official documents that (tied) what we all do. We just want to make sure that you all understand that. Occasionally we misstate, it has happened. We've done about 90 to 95 of these calls and there had been one or two occasions where we have said things that weren't quite exactly correct.

In such case, what is published on the Web site is what is the official (ruling of all) of the things that we do.

Having said that, I will now ask Bill Ford and (Jeremy Farquhar) at our coordination of benefit's contractor in New York City if they will make their opening statement, gentlemen? Thank you.

(Jeremy Farquhar): Thanks, Bill. This is (Jeremy Farquhar). Just a few things to announce here. First, being the alert that has been posted regarding the HRA, the revised HRA recording requirements. If you are now already aware you should check the CMS Web site for the alert dated 9/27/2011 under NGHP alerts. That Web site for those of you unaware is www.cms.gov/MandatoryInsrep.

So there has been a change to the annual benefit level reporting threshold for HRAs effective as of October 3rd. Only HRA have reached that reflects an annual benefit level of $5,000 or more so you report it. HRAs of annual benefit amount less than $5,000 are exempted from reporting.

Funding deposit amounts rolled over from the previous year's coverage must be included when calculating the current years annual benefit amount. Now,

this applies to all new or renewing HRAs. RREs reporting under the old threshold we'll continue to do so until the end of their current plan year.

At the end of the current plan year, if you are under that $5,000 thresholds and will remain under that $5,000 threshold you may submit a termination date as of the last day of that plan year.

I know that the termination is to be submitted to the COBC. When an HRA has insured HRA benefit coverage is exhausted and no additional funds will be added to the HRA, for the remainder of the HRAs current benefit coverage term. No said termination is to be provided to the COBC by including it in the RRE next regularly scheduled (MSP) (input) file submission.

The RRE may also called the COBC Call Center at 800-999-1118 with no said termination and the CSR will take that termination date and update the record for you.

This will replace guidance that had previously been found within section 7.27 on A-67 of version 3.2 of the NGHP user guide. In getting the termination dates are not to be send upon exhaustion of HRA benefit's.

The termination date provided should be out at the data service upon which the HRA account had been exhausted of all funds. Or in the case that the individual has cancelled their HRA benefit's, whatever that cancellation date may be.

Upon start of the new plan year, a new coverage record reflecting the current coverage years effective date must be submitted on the RRE's quarterly (MSP) file. OK, that's it for the HRA alert.

Next, just some notes about the new TIN address validation process that we've implemented as of 10.1. We expect that RRE should be familiar with these changes by now. But for those of you who may not already be aware, please refer to the revise alert dated by 5/17/ 2011 under the NGHP alert section of the CMS Section 111 Web site along with the sections and address, validation and TIN reference response files within the version 3.2 through the NGHP user guide.

Following is a brief summary of the changes noted within the (aforementioned) documentation. These changes had also been noted on some of our pasts open door form calls so this may be familiar to most of you.

Submission of the TIN reference file will now yield a TIN reference response file. For (SFTEP) submitters, the TIN reference response file should be posted to the (MSP) response directory with the specific name in convention which will allow for differentiation from the (MSP) response. That specific name in convention is battled in the current user guide.

Those RREs submitting via connect to rep must create a new response status of that name to which they wish to have their TIN reference response transmitted. The RRE should be contacting their EDI representatives and providing them with the status of that name in order to – we may update our system accordingly.

Via to your connection direction you have not created that status as of yet, please do so as soon as possible, and get us that information. It's important that this is – we got this as quickly as possible in order that we actually have somewhere to send you your TIN response. I know some RREs are a little bit (hankered) on this so please touch base with your EDI rep.

If we don't hear from you they will be reaching out to you at some point in the very near future.

Prior to October issues pertaining to addresses within the TIN detail records would have resulted in the generation compliance logs on the (MSP) response file. These compliance logs are no longer being generated. It had been replaced by (TN) error codes which will be returned on the TIN reference response file.

If the TIN detail record is to error out and it's not corrected prior to the submission of the (MSP) file. Any corresponding (MSP) detail records which cross reference at TIN will be rejected within into with an error codes.

So the (aforementioned) the RRE will be required the first submitted corrected TIN reference file, and then we'll also need to resubmit the corresponding (MSP) record. As far of the newly implemented address validation process after TIN record passes basic field validation edit's. Addresses will be re-formatted into the standardize format recommended by the USPS.

Changes may include things such as corrections and misspellings. Change in order of components within the primary address (lines) and the application of standard USPS post (abbreviations).

Following address standardization we will form delivery point validation by matching against the (polls) of data base. Addresses matching to those considered undeliverable maybe rejected with an error. So this is more stringent than what you would have seen before the result of this of this delivery point validation. You may see some errors that you may not have seen during the period of time where we were reviewing compliance logs.

So you'll need to properly (add) your addresses that you're providing us on your TIN files. That's it for the address validation.

The last notice is regarding our new unsolicited alert process. Just want to remind everybody that the unsolicited alert process is now open to all GHP RREs. The (detailed) information regarding the unsolicited alert order process may be found in the addendum to the NGHP user guide published on 6/28/2011.

The addendum is posted on the group health plan page within the CMS Section 111 Web site previously reference.

Participation in the unsolicited process is optional but it's highly recommended. Account managers for RREs that have already completed the registration process and chose to participate may opt in my visiting the Section 111 secured Web site, logging in and selecting the RRE information option from the options drop down menu.

From the following page they may click on the edit bottom and the Option Receive Unsolicited Alerts may then be selected.

RREs, you have to – you complete the registration process will have the ability to opt in during that registration process. So they will not need to revisit the mentioned steps.

Unsolicited files will be generated on monthly basis, on the second Sunday of the month. Upon opting to receive the unsolicited files the COBC will create in interested party table for that RRE. This table will include an entry for every add and update transaction posted by the RRE within the past 12 months.

Now, the Medicare Coordination of Benefit's contractor receives information from a variety of sources. On occasion records submitted via the Section 111 process maybe updated based on information coming from source other than the Section 111 RRE themselves.

In forming the Section 111 RRE sets changes to their records is the purpose of the unsolicited response file. The unsolicited response will provide the RRE of information on the type of (MSP) from which the update was received along with the entity name and the general reason for the update when that reason is available.

(The file) will also contain all the current data elements as they appear within the record at the time of the response generation. So the changes that were made to the actual record on file, those data elements they'll return to you unsolicited response.

These alerts will provide the RRE with insight into the current status of their coverage data on Medicare's data base. It's also our hope that they may act as a catalyst for resolving possible datas (discrepancies) between the different information sources namely the RRE and employers, and other entities as such.

Once you've benefit at the unsolicited response process is they provide the RRE with the ability to submit a hierarchy override code under (MSP) file without first receiving a hierarchy reject (error).

The situation where an RREs coverage record is updated by (MSP) (above them) on the hierarchy tier the RRE will receive an unsolicited response record. And if carefully after (carefully) reviewing their data. If determined that the update had been inaccurate or if further changes are required to that record they may then submit a hierarchy override code without first having the way for their (MSP) record to be rejected based on the hierarchy guidelines implemented in April.

And with that, I'll hand it back over to Bill Decker.

Bill Decker: Thank you very much, (Jeremy). This is Bill again in Baltimore. I have a few comments to make on some of the questions that were sent into our Section 111 Web site mail box.

Since the last call we had which was in the beginning of September, we've had a few questions come in. Most of them are (Jeremy) just addressed with his information. I'm going to take a look at some of the others that came in to and comment on them.

The first one I want to talk about here is someone who has a question saying that they were thinking about beginning a new HRA for 2012, and needed to know if they have to comply. Up until a couple of weeks ago the answer would have been yes but now they don't actually.

Because the maximum amount of that HRA over the course of the term of that HRA was going to be $1,500. And as of October 1st they only need to report on any new HRA that is $5,000 or more as the value of the HRA over the term of the HRA. The term basically how long the HRA is in effect if there's money in it.

As (Jeremy) has mentioned, and I'm sure all of you have seen, we do have an alert up on the Section 111 GHP Web site that says that that beginning October new or renewing HRAs that are less than $5,000 in value, in benefit value will no longer have to be reported. Only HRAs that are $5,000 or more will need to be reported under Section 111.

So anyone out there who is thinking of or wondering if they're going to have to report their HRA after the 1st of October if it was new or if it was renewing for it's regular term, if it was less than $5,000 you don't have to. You can but you don't have to. I just want to point out that also. We don't tell you, "You shouldn't" (I mean) we don't tell you "You can't". We do say that you don't have to.

The next question I'm going to address comes to us from gentleman who actually gave us four questions. And only one of which I'm going to address here because the other three were already discussed.

His question was basically that the letters that come from CMS, he says name the HRAs TPA is the insurer. He claims that TPAs don't in fact pay any, they don't have funds to pay. They're just moving money back and forth.

The answer, the response of that question is basically that may be true is the RRE, the Registered Reporting Entity that is the insurer in this case. And it's the RRE that needs to deal with situations in which the, I don't know how best way to put this, in which there is money or not money available on an HRA to pay.

If the TPA is not the RRE the TPA should not be having to deal with request from providers for payment, they should be passing them on, that on to the RRE. That's the RREs responsibility because any questions about reimbursement go to the insurer not to simply the insurer's agent.

TPAs are frequently insurers under Section 111, I do want to mention that again. In the case of this gentleman it was clear that he was acting not as the RRE but as another entity entirely.

Another question that I want to address came in from someone before our new alert went up. And that question was about an HRA that's being use to pay…well, let me read this to make it clear to all of you because this question has come up frequently.

The employer buys a health plan with $2,500 hospital deductible. The employer tells the employee that the employee will need to pay the first

$1,250 of a deductible. And the employer will pay the remaining $1,250. This is called a Bridge HRAs. What the exact text of the question was, I'm assuming that that's the employer part is called the Bridge HRA.

Again, this is going to be an HRA now that is under the $5,000 reporting threshold. So this question is no longer actually in play.

The number of questions came in that as if contributions made by an employer to an employee in the form of assistance so that the employee could meet an insurance deductible or co-payment should be reported. The questioners did not explicitly say that this will be reported through a health reimbursement arrangement.

Our answer to any questions that aren't specific like that would have to be, well if it's an HRA then you have to consider whether or not it needs to be reported. Remember that CMS doesn't actually define what an HRA is. That definition except for reporting purposes, the definition of an HRA is actually determined by the Internal Revenue Service recording rules and construction rules for HRAs.

In other words the IRS determines what an HRA and CMS doesn't. if what you have is an instrument to use to reimburse employees for expenses, for insurance cost is classified by the IRS as an HRA then it would have to be considered by (usual) reporting under Section 111.

And if the value of that HRA over the term of it's benefit period is $5,000 or more than, yes, it will need to be reported.

Let me just see if there's anything else here I want to talk about. a couple of people actually wrote in and ask about using or what we called the model form or a model letter for finding/collecting Medicare Health Insurance claim numbers or Medicare HICN or/and lieu of a HICN on Social Security number.

And one question they said is, "Is it OK just to keep that on file if they don't respond?" And as we said many times but it's worth repeating, if you're having trouble collecting primary ID numbers for folks particularly Medicare

Health Insurance claim numbers or in cases where you need to collect them Social Security number for an individual.

And you cannot collect it from the individual for whatever reason. And you try to collect that using the model language that we provide and you still can't collect it. Your responsibility at that point is just to keep a copy of the model language and discretion of the efforts you went through to try to collect that information on file.

So that if it ever comes to that you can show us that you did try to collect the information and it was not collectable. That will keep you in compliance with our reporting requirements.

The last question that I'm going to address comes from large insurance company actually. It's something that they referred to us a health incentive account. Your question is I can't find anything about that in the user guide and ask some questions about that and can't find anything in the user guide about it because this is not to be reported. The health incentive account is not an HRA.

An HRA is not an HIA. An HRA is not a health savings account neither health savings account nor health incentive account, nor any other sort of in tax instrument like that would need to be reported to us. Only an HRA needs to be reported to CMS under the terms of the Section 111 guidelines that we have out on our Web site and our requirements for reporting.

I've been asked to remind everyone that $5,000 or more amount is a reporting threshold, and that means that once again if it's under $5,000 you need not report it. If it's over $5,000 you do have to report. Technically we would say $5,000 or more that would have to be reported as your HRA.

And remember that regardless of whatever amount it is that has to be reported to us you're still responsible for paying appropriately. Remember that you're not reporting anything to us except the coverage. You're not reporting under Section 111 (inaudible). You're not reporting anything about the amount of money that you're paying or how you're paying it or as the other details of filling in reimbursement.

You're only telling or since you're actually covering someone with an HRA instrument. And with that, I have finished my piece of presentation here. Is there anyone else here that wants to say anything? Apparently, not.

And so, operator, at this point 1:30 we can open it up for questions from our callers.

Operator: At this time, I would like to remind everyone in order to ask a question please press star then the number one on your telephone keypad. Please, limit your question to one and one follow-up. We'll pause for just a moment to compile the Q and A roster.

Your first question comes from the line of (Shamim Habib) from Dean Health Plan. Your line is now open.

(Shamim Habib): I want to know, can somebody takes a (vow of poverty) and that person has only been reported to CMS. How do we term their coverage without – if the person hasn't ended their group health coverage? Could we use the termination date attribute on their file to send the termination off their (MSP) occurrence with CMS?

Are the CMS have any other ways of finding that information, and we don't need to do anything?

Bill Decker: Are you asking a question specifically about HRA reporting?

(Shamim Habib): No, it's about the (inaudible) which is also one of the, you know, requirements which are separate from HRA.

Bill Decker: More generally, what you're asking what do your report as a termination date?

(Shamim Habib): Yes. How do we report it to you guys? We have tried to get this answer from, you know, from the COB contractors many times but we don't find anything in the guide and we're getting a good answer to our question either.

So we are basically saying, if the person is working for religious order they are generally exempt from, you know, being reported for (MSP) purposes.

But if the person has only previously being reported now we only need to term them. What attribute, I mean, there is no specific attribute on the (MSP) input file that we could use other than the termination field which is generally used for the group termination.

Could we use the same field to report that, you know, to report that termination?

(Jeremy Farquhar) : Yes, that would be appropriate. If they were, but it depends, if you had report to them they're taking (poverty) and they really shouldn't have been reported in the first place.

(Shamim Habib): No, I mean, in my case what I am to really struggling with is when they should have been reported. So the ABC person works for a religious order but did not have the (vow of) poverty, you know, before but decides to do it says six months into the coverage.

At that time, you know, the first six months she should be reportable. But from that point onwards basically she is non-reportable. So should we term it at that point?

(Jeremy Farquhar): Yes. The termination date as of the date today (vow of) (poverty) just the standard termination date field on your record lay out.

(Shamim Habib): And it would be appropriate to use the termination date field that we would generally use for the group health termination, right?

(Jeremy Farquhar): That's correct.

(Shamim Habib): OK. Thank you.

Operator: Your next question comes from the line of (David Piot) from (PEA Consulting), your line is now open.

(David Piot): Good morning, Bill. This is (David Piot).

Male: Hi. Good afternoon.

(David Piot): Hey, I have a question about the $5,000 threshold. If the family of two has policy then it's of $3,000 for each members so there's $6,000 in total. Do we have to report each individual?

Bill Decker: Yes. You've always reporting on an individual by individual basis, remember your reporting coverage for a human being. If there…I know your question if it's family coverage…

Male: Each has access to $6,000.

Bill Decker: They're right. They would access to – if it is family coverage and it was $3,000 each that have access to $6,000 (inaudible) affordable.

(David Piot): OK. Well it's kind of, just to clear, I mean if the family has a limit of $6,000 then either one of them can spend up to $6,000 then that seems like it's reportable.

If the family has $3,000 as individual's each so that one would max out at $3,000 and those particular individual under that policy wouldn't be reportable, correct?

Bill Decker: I would say, yes.

(David Piot): OK, cool. Thank you.

Operator: Again, if you would like to ask a question please press star then the number one on your telephone keypad. And if you would like to withdraw your question please press the pound key.

Your next question comes from the line of (Susan Scardina) from (inaudible), your line is now open.

(Susan Scardina): Thank you. I have a question regarding the $5,000 HRA limit also. If someone has, say $5,000 for the annual amount and then we allow them to carry their (inaudible), to carry money over into the next year. So maybe they only use a thousand and now they have, let me say they have 4,000 the first year and they can carry over thousand.

So now the next due they have $5,000 but their annual is still only $4,000. At some point they could use it all. I mean, when do we start reporting them at the time that the carry over and their annual equals to $5,000?

Bill Decker: Yes, we try to make it very clear that when you're figuring the amount of a benefit plan for an HRA, if there is a carry over from previous years that carry over amount needs to be combined with the funding from the current plan year.

So if the funding in the year before was $2,000 and the funding in the current year is going to be $4,000 and there's still $2,000 left from the previous year. The total funding for the current year will be $6,000 and that's a reportable amount.

(Susan Scardina): At the time it hit's over $5,000, right?

Bill Decker: That's right, $5,000 or more.

(Susan Scardina): OK. Yes, because a lot of the plans it's unused money they get to carry over so it's hard to predict in the beginning when they're going to hit that $5,000. so once they do that's when we start reporting them, right?

Bill Decker: Correct.

(Susan): OK. Thank you.

Operator: There are no further questions at this time. I'll turn the call back over to the presenters.

Bill Decker: OK. Hi. Thank you very much, operator. This is Bill Decker again. I'm going to give everybody about a minute more to come up with some more questions if you have any.

Again, this is a general HRA rather NGHP called (inaudible) call. We can take questions that are not related to HRAs if you have any. And if you do please call in right now and if you don't then we've been happy to talk to you.

Operator, do you have anyone else's rung in?

Operator: There are no further questions at this time.

Bill Decker: OK. We'll conclude right now. Thank you very much, everybody. We appreciate it.

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

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