TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b)(7)

DATE OF CALL: January 26, 2010

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

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS' DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: John Albert
January 26, 2010
12:00 p.m. CT

Operator: Good afternoon, my name is (Kim) and I will be your conference operator today. At this time I would like to welcome everyone to the Section 111 GHR conference call. 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 one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you, Mr. (Ducker); you may begin your conference.

(Phil Ducker): Thank you very much operator. Hi, good afternoon everybody. It is 26th of January in the year 2010. It's 2:00 in – 1:00 in the afternoon, five after one in the afternoon on the East Coast of the United States. We welcome everyone to their Section 111 national teleconference call. This is a Group Health Plan, a GHP conference call. If you have a non-Group Health Plan question, NGHP question, either technical or policy this is not the call for you. You can leave now and come back and join us on Thursday when we have our next scheduled NGHP call. If you are IGHP reporter and you have comments and questions you want to ask us or give it to us after we do our presentation, please stay on the line you will be able to ask us questions as we continue on in this two hour call.

I am here this afternoon with (Pat Ambrose) and (Pat) in a moment will be giving a presentation to you, an opening presentation and then I will follow her with my own special presentation and once those are done, we will open it

up to questions. So I urge you to pay strict attention to what (Pat) and I will be saying because we haven't had a GHP call on sometime. And this is the first of the next series of three before all you Group Health Plan folks will be going live to report to us later on this year. So I will now turn over (Pat Ambrose) who will have a chat with you, Pat?

(Pat Ambrose): Thanks (Phil), first some general announcements. Recent postings to this Section 111 website you can find that at www.cms.hhs.gov/MandatoryInsrep. You will see that there has been some website reorganization, a couple of new tabs or options off the left menu. In particular, there is a new tab or left menu option entitled "MMSEA 111 Alerts". Under that or on that page you will find some specific alerts that CMS has posted related to Section 111 reporting. Also to the bottom of that on the left menu is right now a tab entitled mandatory insurer reporting. This page is not quite done, but when it is, it will be a dynamic list that will eventually be populated with all mandatory reporting documents related to Section 111 that can be sorted by date, title, subject, a description and so on. So this should help folks with some of the problems that we have had running out of room, posting documents to section 111 website. Again, this is still a work in progress, not all documents have been posted on that particular page. And you will receive notification via an e-mail notice and the "What's New" page when that is completed.

Speaking of the e-mail notification - we did have a problem prior to the beginning of the January with the e-mail notification that you should receive when the website is updated. You will see a link to find out for those notifications, if you haven't done so already. However, that notification was not operating properly, that has been corrected. But just as a reminder it's a good idea for you to check the website on a frequent basis, particularly the "What's New" page and off course the GHP page related specifically to the GHP reporting issue. Out on the alert page then you will see an alert that was dated December 23, 2009 regarding the addition of document control numbers to the query file process and the upgraded HIPA eligibility wrapper or H-E-W, also pronounced the "hu" software. That same information then also has also been posted in the updated group's health plan section 111 user guide. On the GHP page you will find version 3.0 of the GHP user guide, dated January 4th, 2010.

Now for other reminders related to ongoing reporting of your section 111 files, it appears that we are seeing some submission of records where the RRE is changing the insurance coverage type without also submitting the proper delete add or update add process. Remember that the insurance coverage type field is the key field and requires special consideration when you are submitting updates to that information. If you made a mistake and correct the coverage type sent originally then send a delete with the old coverage type, followed by add with a new coverage type. Again since that coverage type field is a key field. If the coverage type changes but some coverage continues and what you sent originally was actually correct but it has since changed, the coverage for that individual has since changed; you are to send an update to terminate the original coverage. So send an update with a termination date and then send add with a new effective date for the new coverage type. Yes Phil, would you like to add...

(Phil Ducker): I just want to ask a question for clarification, can you send it delete record, followed by an add record on the same input file?

(Pat Ambrose): Yes, absolutely.

(Phil Ducker): OK, I wanted to make sure we all understood that.

(Pat Ambrose): Yes, absolutely. They should be put in that order in your file, but I don't think it actually makes a difference. But yes, the delete add and the update add that I refer to can and both should be sent in the same NFP input file. In addition to that note that it would make sense in the case of changing your coverage type that the termination date and the effective date of the change be one day apart. So in other words, the effective date of the new coverage date would logically be a day after coverage under the old coverage type was terminated. So again, I'm often seeing records being submitted, where the coverage is, an update is being sent to terminate, but the effective date then on the add record with the new coverage type is equal to the termination date, which is - seems somewhat unusual to me. So you might want to double-check your systems for that.

Another suggestion on formatting address field, I will be updating the user guide with this information in the future, but to ensure that the coordination - the benefits contractor, the (COBC), and the MSP recovery contractor are reaching out or contacting proper entities and getting to the proper address. It would be helpful for our ease to make sure that the address line 1 field should mainly only contained street number and street name of the address. If you are things like apartment number, floor number, suite number, attention to, instructions or internal mail drop number, things of that nature should go on address line 2. As covered previously, some reminders that you must process you response file. It contains critical information regarding your section 111 submission. Process your response file from the last quarter first before sending your next quarterly submission; even if that means that the file would be late.

(Inaudible) I would rather have it done correctly and submitted on time, but without the proper processing. So, again you cannot really create your next quarterly file submission without processing your previous quarter's response file and reacting to information sent back to you as per the user guide instruction. Please only submit the delete records in the case where the record was previously accepted with the 01 disposition code. There is no need to delete a record that was sent but not accepted and in fact, it will be returned with an error. Remember that you're not to delete a record when an individual's in GSP coverage ends; please send an update record in that circumstance with a termination date.

Files that are completely rejected or have a very high percentage of records rejected, for example possibly of a TIN reference file record was not submitted or accepted. These files are to be corrected and recent as soon as possible. Please do not wait for your next quarterly file to fix a serious problem such as this. When you have a file, that has high, very high percentage of records rejected or completely rejected, please contact your EDI representative to discuss a plan for submitting the corrected file as soon as possible. And one last reminder, if you have mistakenly included retirees who are not ESRG patients on your MSP input file, remember you are MSP input file should only include active covered individuals. Please review the definition of active covered individuals in the user guide. But if you did not

have proper information from the systems that said your section 11 process or whatever might have been the problem, if you come to the conclusion you have submitted retirees erroneously on your MSP input file do not wait until your next file submission to correct that. Again, please contact your EDI representative immediately and work out a schedule to send in corrected records on a file off your normal quarterly file submission schedule.

I'm (now) going to go into some of the question and answers that were or questions rather that were submitted to this section 111 email box and provide some answers to the ones that I can on this call. First of all, if you receive compliance flag back on your MSP response file, it indicates that the record was submitted with an invalid insurer or employer TIN, but if believe that the TIN is indeed valid then please contact your EDI representative. Upon receipt of adequate supporting documentation, the EDI rep will mark the TIN as valid in the (CLBC) system for section 111 and you will no longer receive these compliance flag on subsequent file submissions. Again it's up to the RRE to contact the EDI representative with appropriate supporting documentation that the TIN in question is indeed valid. You must make that contact to your EDI representative so that they can validate that and update the system accordingly. It won't happen or be researched any further, automatically. And obviously some follow-up at a later date will be done this compliance like, so it's in your best interest to address those issues now.

I can't say specifically exactly what documentation you are EDI representative will request regarding validating the TIN, but you should work that out with your representative. It's one of those situations where it might depend on what is actually available.

A question was submitted regarding the submission of the termination date for reports of GHP coverage on the MSP input file. The submitter stated that due to enrollment being determined on a month-to-month basis, they may be sending an update each quarter with a new termination date. Note that this is not an acceptable reporting technique. First, we recommend that you make use of the query function, if possible and determine Medicare entitlement prior to MSP a record submission. That isn't required, but it might make your processing a little bit smoother or easier. Second, if you do not have an

absolute date of coverage termination, in other words, you do not know whether the coverage will be extended next month or not in the circumstance, when submitting the initial add record for that individual's coverage submit it with see zeros in the termination date.

In other words provide an open-ended termination date. Then only when you determine that the coverage was terminated or ended when you find out that that individual is not any longer covered, then submit an update with a termination date. So instead of recording a different termination date each quarter, record the record with an open ended termination date until such time you determine the coverage has actually ended. And then submit the termination date subsequently. There is always going to be a timing issue when it comes to reports of coverage termination date. And we can't really do much about that. Of course it won't matter if this MSP occurrence is out there indicating that the GHP coverage should be primary and not Medicare for certain period of time, unless the claims are actually submitted to Medicare or the other carrier. And in that case, it is possible for beneficiaries to reach out directly to the coordination of benefits contractor to have that record – MSP record terminated sooner than an RRE can record. But the RRE has no a big obligation to report it other than their regular quarterly file.

The same question also or submitter was also asking about sending multiple records in one file reflecting different coverage information with different effective (in term) dates, on again one quarterly file submission for one individual, and there is no problem. Again review the key fields and information in user guide regarding this. But if you are reporting for an individual for the first time, particularly, you may very well have multiple records that you need to submit. It could happen that you have multiple records, to submit in regular quarterly file. Again, multiple records are expected if the key fields are different for that individual's coverage.

Another question was asked about, what an RRE can do if they are unable to obtain employer TIN information. As you know in the current user guide, starting January 1, 2000 RREs were supposed to have obtained an employer’s EIN or tax identification number or TIN or corresponding information so that they may submit that information on the TIN reference file and MSP input file

record. Please review section 7.2.2.1 of version 3 of GHP user guide, very it does explain that if you still don't have the employer TIN, then continue to submit the record with a pseudo TIN as appropriate. However, you will receive a compliance flag back. Now if an employer is questioning the requirement for them to provide disinformation, you should refer them to the MSP statutes, MSP regulations and the Medicare MSP manual. These statutes, regulations and location of the manual are documented in the GHP user guide rather than reading off the actual sites or where that legislation and regulation can be found, please refer to the user guide. MSP manual can be found on the CMS website, and the user guide includes the link to that as well to. Note that the Medicare MSP manual is publication 100 – 05. In addition to all of that, you can refer the employer to the Alerts CMS posted on the Overview page of the section 111 website, there is a document dated May 6, 2009 entitled Alerts to Employers.

Another question was asked about what to do in the case of initially sending multiple records of coverage say for coverage period between January and March under one type of coverage and April and on under the new coverage and the individual is not matched to Medicare beneficiary. In other words, you submitting this individual on your MSP input file as an act to cover individual, they are not yet entitled to Medicare, their information is not matched to a Medicare beneficiary and you receive a 51 disposition code back on those records. In first you need to make sure that your submitting accurate information for that individual for the matching to be successful. If you're confident that your submitting accurate information for that individual and they are just not a Medicare beneficiary as of yet, you only need to be concerned about the sending or the taking the current coverage information going forward. See section 7.2.9.1 of the user guide where it states, if a record was rejected with a disposition code of 51, which indicates the active covered individual could not be matched to a Medicare beneficiary, you must continue to resend the current information for this individual going forward. In your subsequent quarterly file submissions until it is (accepted), you coverage for this individual is terminated or the individual no longer meets the definition of an active covered individual. In other words, their employment has ended, they have hit retirement etcetera.

Alternatively you may use the query process to monitor the Medicare status of the active covered individual and resubmit the MSP input file record, only after determining that the individual is covered by Medicare or covered by Medicare and remains an active covered individual, and again you only have to send the most recent coverage information. Since obviously they were not in – their prior coverage would not have overlapped the Medicare coverage, so it's not pertinent to this reporting process.

Another question was submitted regarding the SPES error code, SPES and the ES standing for employer size. This error code is posted related to the notification back to the RRE that the (CLBC) did not create an MSP occurrence due to the employer's size information that was submitted. So SPES means that (CLBC) did not create an MSP occurrence due to the employer's size reported and the reason of course for individual's Medicare entitlement. I'm not going to go into all of the rules related to employer's size, you will note that we added appendix I to the last version of the GHB user guide that provides a lot of information related to employer size and how it affects section 111 reporting. But generally speaking, Medicare is secondary for the working aged only if the employer size is reported as 20 or more employees. Of course there is a small employer exceptions related to that. Medicare is secondary for the disabled, only if the employer size is reported as 100 or more employees. And again that's just a broad overview of the MSP rules related to employer's size.

(Phil Ducker): You may want to remember that in some instances you are not reporting the employer's actual size in the case of multi or multiple employer health plans. You would generally I believe, if it was a multiple employer health plan and any employer participating in the plan that at least a 100 employees, he would report 100 for all the employers.

(Pat Ambrose): Yes (Phil), and all of that is indeed covered in that new appendix I. And the real question here was related to then what was returned on the response record. So if the employer's response was reported as less than 100 employees and the individual is entitled to Medicare based on disability, then most likely the (COBC) is going to return SPEF error code. An SP disposition code and SPEF error code. So that's the reason why you're

receiving the SPEF. And there are instructions in the user guide as to how to react to that. I don't know why though on the response record, the entitlement dates for that individual Medicare beneficiary were not returned. We are looking into that. I'm jumping to the conclusion that it is probably due to the disposition could have (inaudible) returned to you. So we will investigate as to why the – you know obviously if you are getting an SPES the individual reported must be a Medicare beneficiary and you would think that the response would include the entitlement dates. But apparently it's not the system is not returning that. But do note that you can always query that individual (you see) queried only file, to query that individual to get those Medicare entitlement dates and Medicare coverage dates if you need them.

OK, let's see, we have a couple of other questions that came in – late breaking questions, one is about the compliance codes that are returned on the response file during testing. So this is a question coming from the GHP submitter who is still in testing phase and they are asking about do they have to worry about the compliance codes that are coming back during testing. I would say not particularly but if those are TINs that you are planning on submitting in production, on production files you may want to contact your EDI representative now and determine the reason for the compliance flag and provide supporting information like we talked about before related to these being valid TINs so that they can get the system updated before you submit them on production file. So you don't have to, getting compliance flags on your test files will not prevent you from passing the testing requirements and going to a production status, however it is something you want to follow-up on for production purposes anyway.

Also this question went on to ask about the age threshold. Right now, if you look at the definition of an active covered individual. It includes reporting individuals who are covered due to active or current employment and are over the age of (55). And then these threshold changes to 45 and older, however, that change does not go into effect until 2011. The questioner was asking about it starting in 2010, and if you go back and reread the definition of active covered individuals, you will see that lowering of the age threshold does not go into effect until January 2011.

One last question relates to a game that the timing on the reports that GHP RREs are making. So suppose that you have submitted GHP coverage and a MSP occurrence has been built at Medicare. That indicates that the GHB coverage is primary and Medicare is secondary. Then prior to the submission of the next quarterly update file the individual retires and is no longer an active covered individual. So there might be a period of up to three months where that MSP occurrence is out there indicating that the GHP is primary and not Medicare, however that's not actually the case. Unfortunately, again, there is a timing issue and an RRE is not required and nor do you even have the ability to send an update with a termination date for that MSP occurrence until your next quarterly file submission. However it is possible for - and again, this won't affect the beneficiary and their claims payment, unless they actually have claims being submitted to their insurers GSH and Medicare at the same - during that period of time. And if there are problems with payment of those claims it is possible for the beneficiary to contact the (COB) contractor and report their retirement and have that MSP occurrence updated and terminated in a more timely fashion if it is causing a problem with their claims payment. So you know again we don't really have the ability to allow you to send update any sooner than that at this current time.

So that's all I have to present at this time and I will now turn it over to Mr. (Phil Ducker) for additional information.

(Phil Ducker): Thanks (Pat) very much. Just for the records we were joined after the call started by Mr. (Bill Zavonia), who very kindly answered that question about the (inaudible) exception, who is our expert in that area and thank you (Bill) for coming in.

I have a couple of subjects to cover. I'm going to talk about some of the questions concerning collections of social security numbers and I am going to speak to new material that was published in the GHP user guide regarding health reimbursement arrangement reporting. But before I do that I do want to mention one other item quickly. We got a question in from a non-Group Health Plan questioner, but that's a question that is applicable to everybody and that is the question is exactly this if some has ALS which is more commonly known as "Lou Gehrig's" disease, does that make them a Medicare

eligible beneficiary or Medicare eligible recipient? And the answer is yes in fact.

Anyone who is diagnosed with ALS, of any age is eligible to become a Medicare beneficiary. They achieve their beneficiary status by applying to Social Security Administration or enrollment in the ALS program that they have there. They get Social Security disability insurance as a consequence of that. And once that insurance is in place, they are Medicare beneficiary. And the reason I brought that up is because there are a lot of times we get a lot of questions from folks asking us about why we, why Social Security numbers updated when it's clear that some people don't have them or some people don't want to give them or just why exactly is that we ask for Social Security numbers. I will process all that by saying that the primary identifier for anyone reporting to us under section 111 is the Medicare ID number, the Medicare HICN, the Medicare health insurance claim number. That is the primary ID number, that's why have said consistently over the past 14 months or so we have been doing these calls and it still is true. The primary identifier is the Medicare HICN.

It may be a case that a RRE does not have a Medicare HICN or an individual the RRE thinks that maybe Medicare beneficiary or is just curious to find out whether that individual is a Medicare beneficiary for purposes of section 111 reporting. In such case the RRE can send us the individual's social security number with the first initial of their name, the first five letters of their last name, their date of birth and their sex identifier, they are wither male or female. With that information we can check our Medicare beneficiary database and respond to the questioner and let the questioner know whether or not the individual is a Medicare beneficiary or not. And that's essentially all we will respond with, we don't respond with any other information about the individual – just yes or no. If the answer is yes, there is a Medicare beneficiary; we will provide the individual's Medicare health insurance claim number in our response file. We don't' have a Medicare health insurance claim number we simply say that we didn't find a beneficiary. That process, the RREs have access to and that we encourage them to use if they have questions – excuse me – has driven a lot of questions coming from RREs to employers and to employees about the collection of SSNs.

Remember that our requirement is a health insurance claim number or a Medicare ID; it is not a Social Security number. It is useful to folks who need to report to us if they have SSNs but it's not a requirement under section 111 reporting law that says that anybody has to collect SSNs in order to report under the section 111. We want to make that clear, there are valid reasons for people asking for social security numbers and there are valid reasons for using them and we all need to keep that in mind as we are going through the process here of working with section 111 reporting.

I'm (now) going to get into some of the actual questions that we have had coming into us since we last had a Group Health Plan or GHP national teleconference. This is a question from someone who has said that we have an issue and we need some guidance on we have members, we have some members that because of discrepancy with the SSA data we cannot get the three or four match in order form CMS to create an MSP record. What should we do in that case? Should we notify these members of these discrepancies and hope they are willing to take on dealing with the SSA to correct them, but what if they don't? This is a situation in which the information that was provided to an RRE concerning Social Security ID number and accompanying personal identifiers that are necessary to do a valid query with us were incorrect somehow.

And the questioner here wants no, how do we make sure that we get correct data, what do we say to the individual? And the answer to that is that it's up to the individual to go back to the Social Security administration and find out why it is that information that is in possession of the RRE is not in fact valid as far as matching against the Medicare beneficiary database. Remember that the Medicare beneficiary database is developed from information, which is in the possession of Social Security Administration. If the Social Security Administration information does not match what's on the Medicare beneficiary database, we would be very surprised. The point is that if you can find information on the Medicare beneficiary database because you have been given incorrect of seemingly incorrect or seemingly invalid Social Security information is nothing that CMS can do about that. It has to be taken care of by the individual.

You have to just say to the individual I am sorry but there is nothing that we or CMS or the Medicare program can do here, you are going to have to go back to social security and find out what the issue is here. One of the things that you might want to mention to this individual is that if there is incorrect information in the hands of the employer for example, they may not be being credited with their employment for social security purposes. That would be a large issue for me and I would certainly be a large issue for other folks too. But basically it's the individual's responsibility to see that their social security information is correct to the degree that they can and get back to us with, or get back to you all with the corrected information.

We have another question that came into us saying that the client of our office is inquiring (inaudible) responsibilities to submit social security numbers for each of their employees even though if it's not currently on the Group Health Coverage. Apparently they received a notice from an insurer demanding social security numbers for every employee that they had in the company. And our response to that is that first of all it's not CMS that's demanding the social security number, it is the GHP insurer. Secondly CMS only wants to have the Medicare ID numbers. More generally if someone is not covered by the employer's Group Health Plan, there is no reporting that could be made under section 111. If you are not a covered employee under the GHP coverage offered by an employer and you are not a Medicare beneficiary there is no way that there is actually no reason for anyone to try to report information about you to Medicare. As a consequence of that you may question why it is you are being asked social security number under those circumstances?

Again we say if there is no coverage now there is no need to report and there are no IDs that are needed to be collected. If and when however when you do become covered, under an employer's Group Health Plan coverage then you will have to furnish an appropriate identification to the insurance company that is providing the coverage. They will ask for what it is they believe they need and if it is that you are a Medicare beneficiary, you will have to give them your Medicare ID number. The law does say that. Again no section 111 requests to collect social security numbers. If you have an issue, if anyone out

there, if any individual has an issues with these sorts of request coming in from anybody, they can go on our website and download a document called "The GHP model language for HICN/SSN Collection" it's a August 18, 2009 revision and it is on the What's New Page of the section 111 website. And it can be used by any individual, you have to either supply the correct information to whatever I was asking for or to not supply it or to say that you don't want to supply it or to say that they are refusing to supply it and that document is to be signed by the individual who has the information and provided to the entities that is asking for the information. If the entities that are asking for the information has that document in the possession, a copy of that document in possession. That is evidence to us at least that they did try to collect the information that we require.

We have another social security number question, regarding the social security numbers of dependents. Under section 111, must a Group Health Plan or the employer submitting information to the Group Health Plan collect all the social security numbers of the dependents? What if the Group Health Plan knows dependents is under 14 years of age and has no reason to believe that the person is otherwise eligible for Medicare, etcetera. The answer to that question is that the Group Health Plan and the insurer should be working together to provide, the Group Health Plan and the employer should be working together so that the Group Health Plan gets the information necessary to report accurately for whatever reasons that Group Health Plan needs that information for whether is to report Medicare program under section 111 or did you do anything else?

We can't really speak to why an insurer maybe requesting information from an employer we can tell what it is we request and what we require and we need to have if a GHP needs to make inquiries of us. And we have both the user guide and on this call already but we say again that there is nothing that is mandatory to section 111 that dictates how a Group Health Plan insurer and an employer will manage the business that takes place between them. We deal with RRE and the RRE is typically the GHP insurer and not the employer.

Another question we have got is if a plan is – this one, if a plan to refuses to provide the SSN and refuses to execute the CMS document explaining why she, why the member is refusing to provide the SSN, what recourse against the plan member does the plan have? For instance can the plan terminate the member for failure to provide the SSN? Our answer to that is that we don't have to have answer to that specific last part of the question. That is a relationship between the GHP and the employer. If the GHP insurer is saying that we require the SSN for purposes of section 111 reporting that's probably not an adequate reason for any action to be taken against the individual. If the individual is given that document I just gave reference to the document that says I will provide the information or not and the individual refuses to provide the information, as long as the GHP insurer has the record of that refusal in its record as far as we are concerned it has done what it can at this point to satisfy its reporting requirements to us as far as that individual is concerned. There isn't anything else that we can say it should or should not do in its relationship with the employer that particular individual. It's really not the business of the Medicare program to be dictating how the relationships between GHPs and the employers are to work in areas other than in the reporting to us.

The last question, we have on SSNs as currently today, what is the impact on the report if you have incorrect information. For example, the name or Social Security number is incorrect. (William), would be me is actually the first name of the social security card, but what we sent through is (Bill) because what we sent though is (Bill) because this is the name the person generally goes by. This is assuming of course that we have the correct HICN. If you have the correct HICN, you don't need to send us the SSN, unless the individual is also a subscriber to the policy. If you have the correct HICN, you should be able to generate the correct SSN from that, if you did the query. If you had a response coming back to you saying, we believe that the social security number is wrong but you're supplying the correct HICN, you can at least go back to the individual and try to get correction from the individual or you can the Social Security Administration or the individual can. Basically, though, again, the bottom line for us is the numbers to send us are the Medicare ID numbers. We can query on social security numbers but essentially what we're looking for Medicare health insurance claim number. We require a social security number if an individual is the subscriber to a

policy or there is the actual person named as the subscriber to a policy and we require that only because the insurance industry requires it. Beyond that we don't have any particular requirements.

He is another question, what does an employer do if a third-party administrator is requesting missing Social Security numbers to comply with section 111 but the participant's (inaudible) to request are corrected do not have the social security number. For example, they do not receive wages in the United States or they are an adopted child outside US waiting an SSN etcetera, etcetera. Bottom line rule here is that, if an individual does not have a social security number in the United States, a valid US social security number, the individual will not be a Medicare beneficiary. You have to have an SSN to get a Medicare HICN. Somebody has to have SSN, a valid SSN for you to get a Medicare HICN at least and essentially if it's someone who does not have a SSN they are probably not going to have a Medicare ID number. And we said that on a lot of these calls also when we still get this question basically no SSN, no need to report because they are basically not going to be a Medicare beneficiary. Remember you are only reporting to us about Medicare beneficiaries.

The final question from the SSN perspective is – my daughter works for a small business that has a group health plan but she is not insured with the group but rather she is insured through her husband's employer, is there any reason for the insurance provider for her employer to be demanding her SSN and other personal data. Not as far as reporting for section 111 is concerned is our answer to that. There may be other reasons, but it does not have anything to do with reporting to us under section 111. If she was a Medicare beneficiary and if it was required, someone was required to report information to us under section 111 it would be her husband's GHP the one that she has named as a covered dependent under, not the coverage that is being provided to her employer for (home) she isn't not even enrolled.

If you have further questions about these SSN responses that I have given, you can certainly bring to our attention later on in the call. I want to now (note) to the number of questions we have about health reimbursement arrangements which is a category of coverage, GHP coverage, that we discussed for the first

time in the GHP user guide with this current new edition. In fact, all of page 68 in the user guide, the GHP user guide is devoted to the discussion of the coverage for health reimbursement account reporting. And based on the questions we got in, most folks at least based on these questions understand it pretty well which really is a personal delight to me. We thrashed this about a long time and I am glad that we were able to get these requirements out to everybody and everybody seems to understand them OK. We have a few questions about them and I will go through those now. And then we will open it up for your questions.

The first question on HRAs is - I (inaudible) who asks this question, employers who purchase a fully insured Group Health Plan will rely on the insurer as the RRE – that's correct. A small segment of these employers although covering employees' independence with the fully insured plan will also offer an HRA. Because employer reporting is already being done by the GHP insurer, it is redundant to report the employer offering the HRAs to also report. I stop at this point and say these things about that. First of all, employers will typically be not reporting to us as an RRE if they have purchase HRA GHP coverage for their employees or providing for their employees and they are not self-insured and providing it that way. Someone else will re reporting to us as the HRA RRE.

Male: Most HRAs have a third party administrator.

(Phil Ducker): Most of them do which is why we set it up the way we did. Second thing is that I will remind everyone that we do have a $1,000 reporting threshold for HRAs. Remember that anyone who is offering HRA coverage to employees and the coverage is for a less than $1,000 does not have the report the HRA coverage to us in any case. Third is that a lot of what we talked about in the HRA instructions in the GHP user guide and the lot of the way my answers are framed here, is based on the fact that the HRAs are have an IRS definition and we have used and we are working off that IRS definition for example in the fact that we talked about having effective dates for HRA coverage and I will get to this in a moment. But, when we say, I will get to get more expanded on this in a moment, but when we say that the HRA has an effective date of 1/1/2011 that means the HRA coverage first because available to the

beneficiary in this case, to the covered employee more generally on that date of soon after that date 1/1/2011 and it doesn't mean that the HRA coverage because available to that employee before that date at least not to us. It may to other but it doesn't to others. If it first becomes available to an employee on 1/1/2011 that is the effective date. If it was – first became available to an employee on 10/1/2010 that would be the effective date. We have both of those dates in the user guide and we have them both there because we do know that some firms typically, firms offer these as coverage you work on fiscal year basis and may offer HRA coverage based on the firm's fiscal year rather than a calendar year coverage type. If that is the case then you should be if you are one of those firms that offers HRA coverage on a fiscal year basis and your fiscal year starts 10/1/2009 and that is the first date an HRA coverage type becomes available to your covered employees then that is the first date someone will report that coverage to us if it existed. Otherwise, no one has to report anything to us about HRAs unless the HRAs begin on 1/1/2011 or later. We are not asking anyone to tell us about HRA coverage that is in effect prior to either 10/1/2010 or 1/1/2011.

Now, let me go a little bit further along in this first question. Most of the employers functioning with HRAs in this method that is HRAs who also are, the HRA product is also being offered along with GHP product are small employers who are not suitable for true self funded plans. And this particular questioner says isn't that redundant to have to report these HRAs. It is not redundant from our perspective because an HRA is a Group Health Plan under our regulations and under IRS definitions. But in any case under our regulations as the GHP and GHP – it's a GHP insurance product that needs to be reported to us. We have given everybody a $1,000 reporting threshold so that it may not, you may not have to report to us if your HRA value is under that but in any case that's what happens and someone is going to have to report that to us. Most of the time it will be an HRA administrator not an employer unless the employer has offering the product as a fully self-funded employer. Then go to the next HRA question.

Question here is what do we mean by resetting HRA versus an embedded HRA? A free standing HRA is an HRA that is not considered to be part of a product offered by GHP insurer. As a part of an adjunct to the GHP insurer. I

will give you a quick example. A GHP insurance product is being offered to employers by – and this is just an example for illustrative purposes by BlueCross BlueShield of Montana. And BlueCross BlueShield of Montana offers a product that includes HRA component if the employer purchases that HRA product from BlueCross BlueShield of Montana that includes HRA component we would expect that the BlueCross BlueShield of Montana will be reporting on the HRA component of the package that it sells to the insurer because it is in effect the administrator for that HRA coverage.

If however, an employer buys a plan from a BlueCross BlueShield and say of Arizona and the plan does not include an HRA component but the employer wishes to provide an HRA coverage type to its employees, it purchases this employer purchases that coverage or arranges for that coverage from an HRA administrator of some sort, a broker, a firm – an outside firm, if that is the case, we do not consider the HRA coverage embedded as it were. We consider it to be free standing and in that case the administrator, the firm, the entity or whatever it is providing the package that the employer is purchasing is going to be the RRE and we will be reporting.

So, the HRA administrator reports, does it matter that the insurer is or is not aware that the employer has an HRA that pays portion of the out of pocket expense of the Group Health Plan? It doesn't matter for reporting purposes. I will also say that reimbursements of copays and deductibles won't be reported anyway for example. But the HRAs are used to pay down a deductible or to pay down copays this particular employee that activity will not be reported to CMS because that activity is not a covered benefit under the Medicare program. Here is the key for HRA reporting, a report is to be reported if it is paying for services that are covered by the Medicare program. Remember if the HRA could possibly paying for services that someone else to be paying for as well as the Medicare program paying for then it needs to be reported so we can coordinate benefit coverage. If Medicare doesn't pay for the service being reimbursed by the HRA then there isn't any need to report any of that activity to us under section 111. For example, Medicare does not pay for the costs of parking in the medical center parking garage, which are reimbursable under IRS rules and can be reimbursed to an individual by money in an HRA

but that is not a Medicare reportable coverage. And so that would not be reported to Medicare program.

Other expenses such as over the counter drugs and insurance premiums and the likes will never be reported under the HRA coverage because they are not Medicare covered healthcare benefits. Another person wrote in and said I need clarification on whether our HRA needs reports need to beginning of October of 2010 and the answer to that is easy now. We should all know the answer to this one, you have to report it only if it first becomes effective in October of 2010. If it becomes effective later than that you don't have to report it right away. The next part of this question is we currently have a high deductible plan with a carrier, the deductible is $7,000. However, once the participant pays $2,400 the HRA offered his initiated and reimburses additional cost incurred from $2,401 to the end of deductible under $7,000. That sounds to us, sounds to me at least, like the HRA is being used to pay down the remaining deductible on the Group Health Plan, regular Group Health Plan insurance coverage, if that is the case that would not be reported to us. Because we do not reimburse for the payment of other insurance deductibles under the Medicare program. It is the, what needs to be reported us is anything that Medicare would be covering and might have to coordinate benefit payments for with another insurer.

Male: The next payment that it is making above $2,400 is technically supposed to be primary payments to Medicare, because they are providing coverage. They are providing Group Health Plan coverage and in a situation where the Group Health Plan coverage is required by statue to be a primary payer to Medicare. So to the extent that there they making a payment for Medicare covered item or service they need to make the primary (inaudible).

(Phil Ducker): But the payment is the HRA for the deductible for the insurer's coverage.

Male: That would be considered a primary payment.

(Phil Ducker): That's considered a primary payment to Medicare, so that would have to be reported?

Male: Yes.

(Phil Ducker): That's a new for me, and folks you heard it here first. The answer to this question then is that the deductible pay down that is being made by the HRA, so that the deductible for the Group Health Plan coverage is fully paid off would have to be reported to Medicare under section 111.

Male: Because it is considered Group Health Plan coverage, it's the same thing as having two Group Health Plans, Group Health Plan 1 pays the first $7,000 above $2,400 or whatever the number is and the Group Health Plan 2 then pays items and services above $7,000 or whatever the number is marked.

(Phil Ducker): Hey hang on just a second; we are going to go on mute just for a second. OK, we are back and we are going to leave our last statement again and (Bill) has pointed out, just repeat our last statement on paying down the deductible using the HRA:

(Bill Zavonia): HRA is making a payment with respective an item of service. The HRA is primary care to Medicare and it would need to be reported.

(Phil Ducker): An item or service and a paying down the deductible is considered payment.

(Bill Zavnonia): Just a payment (inaudible) with service.

(Phil Ducker): OK, that closes that loop. That answers that question. Paying down a premium would not be considered an item or service, paying down a deductible would be considered an item or service and thus would be reported. That's good, I am glad we got that cleared at this point. In fact, I think is that all the questions I have. The other question that came in was about the fourth quarter versus the first quarter, we have answered that one. So our presentation on this is over now and operator do you want to open up the line for questions, we are ready to take them.

Operator: Yes Sir, at this time I would like remind everyone, in order to ask a question please press star one on your telephone keypad. We will pause for just for a moment to compound the Q&A roster. Your first question comes from the line of (Suzanne Brendtley) from (John Manilli) company; your line is now open.

(Suzanne Brendtley): Hi, my question to you was, if we have, we have two separate entities that report most of our stuff I believe directly to you. Does the employer also have to apply for an RRE number?

(Phil Ducker): No, the employer doesn't apply for an RRE number unless they are something shared in self funding. And in fact in that case would be considered the insurer.

(Suzanne Brendtley): OK, because we are self funded for both plans. So...

(Bill Zavnonia): Are you self-administer?

(Suzanne Brendtley): No, no.

(Bill Zavnonia): Do you have a TPA?

(Suzanne Brendtley): Yes, we have TPA for each plan.

(Bill Zavnonia): OK, the TPA would be the RRE.

(Phil Ducker): Right.

(Suzanne Brendtley): OK, thank you. That was my only question.

Operator: Your next question comes from the line of (Barbara Colson) from SunGuard; your line is now open.

(Barbara Colson): Hi, I think I am still confused about the effective date issue on the HRA and here's where I am confused. I understand that you are saying, you begin to report if they first, if plan first becomes effective 10/1/2010 or 1/1/2011, what is the definition of first become effective, does that mean the beginning fiscal year even if this plan has been in existence for several years and then when that fiscal year period began again or are you saying a plan is in business say for four years, never gets reported and if you do report the one the plan has been in existence for several years but the fiscal year has begin what is the effective date that you report?

(Phil Ducker): First of all we are not asking for any retroactive information about HRA so the first date of coverage for anyone who can report to us regardless of how long an HRA has been in place for particular employee will be 10/1/10 and that would only be if that was the first effective date of that particular HRA coverage.

(Barbara Colson): So the plan that has been in existence in the past has a new fiscal year beginning is never going to be reported, is that correct?

(Phil Ducker): Well, hang on a second.

(Pat Ambrose): Let me see if I can give it a shot. This is (Pat). If the renewal date year to year is 10/1 then you would – the effective date that you would report, the first effective date you would report for HRA coverage would be 10/1/2010. If the renewal date if January 1st then the first effective date you would or the earliest effective date that you would report for HRA coverage is 1/1/2011 and then report going forward. Again if that coverage exists and continues year to year you should be determination date open and not terminate it until that first (inaudible) individual actually loses that coverage and again if you have to change the record for some other reason. But that's what we are getting at that the earliest effective dates for HRA coverage that should be reported are 1/1/2011 or 10/1/2010 depending on when that coverage renews this year?

(Barbara Colson): So we report the first renewal date that began on or after 10/1/2010?

(Pat Ambrose): OK, thank you.

Operator: Your next question comes from the line of (Elizabeth Wilson) from HealthPlans; your line is now open.

(Elizabeth Wilson): Hi, thank you. I would like to clarify the reporting requirements for people under age 55 beginning in 2011. Is it correct that we need to report retroactively on their coverage back to 1/1/09? Or is it that we are only going to be reporting on their coverage effective 1/1/11?

(Phil Ducker): Do you want to answer that or should I? For (regular) or GHP reporting nor HRA reporting but for (regular) or GHP reporting we are reporting retroactively. Back to 1/1/09.

(Elizabeth Wilson): OK, thank you.

Operator: Your next question comes from the line of (Suzanne Holeg) from Independent Health; your line is now open.

(Suzanne Holeg): Thank you. We had noticed on some of our query response files that we have a number of our members that are over 65 but were not getting a match in that we don't seem to be getting a HICN number; in return we don't have any HICN number on file for them. Can you describe scenarios in which somebody over 65 who is a US citizen would somehow not be entitled to Medicare and you know we are trying to follow-up on this but not sure exactly what approach to use.

(Bill Zavnonia): I guess the first question I would have is make sure that you are sending in the correct information on that person. You know if you do not match enough of the information there is going to be no match because you didn't, you had the name incorrect or the SSN itself you sent in was incorrect so that's first thing for verification purposes if possible get a copy of that covered person's social security card or something like that.

(Pat Ambrose): Or their Medicare card, you could ask them directly if possible. But (John) is it not possible that someone over 65 may not have filled out the proper paperwork and signed up for Medicare? So therefore may not be then entitled?

(John Albert): They may not be enrolled if they haven't filled out the paperwork. They may also not be entitled for a variety of reasons including not having worked and paid the required Medicare tax for the "n" years necessary and you typically or that or the fact that they haven't applied.

(Phil Ducker): Right, for the record the person who (inaudible) the last question was (John Albert) who joined us later. And that's exactly right I know personally of a case gentleman I am very familiar with did not enroll, was not automatically

enrolled in Medicare at age 65 because the gentleman did not apply for social security benefits which is pretty much as automatic enrollment into Medicare at that age. And since he didn't enroll and apply for social security he didn't enroll in Medicare. Eligible for Medicare yes, has paid the taxes and have done all the things that are necessary being Medicare but was not enrolled. And he would not have shown up on our beneficiary database even though he wasn't enrolled at age 65.

(Suzanne Holeg): So he is eligible and entitled, if they didn't enroll we would not necessarily get a match then on the query response if we have a social security number, let's all the data is good.

(Phil Ducker): Not necessarily, and that's why we say it's really important to try to get back to the actual individual that's involved there and check with them to see what they think their status is.

(Suzanne Holeg): OK, and then regarding social security numbers we also have a number of members that are not officially refusing but not responding let's say to a number of letters we sent and also contacting their employer which are federal government employers are actually saying that again off the record that they are not going to provide social security numbers of their employees and that they don't ask for social security numbers of the employee dependents. So we are not getting a lot of response in that regard.

(John Albert): This is (John). I would actually like to talk to you about that, only because you know we have worked with the federal employees health benefits plan to you know and our (often personal management) to ensure that this process is coordinated properly and I would like to find out offline a little bit more about what's you are experiencing if that's OK.

(Suzanne Holeg): OK, absolutely.

(John Albert): Could you provide me with, if you don't mind, you can send through the resource mail box or you can just tell me over the phone here your contact information, it's up to you. Actually, could you send your contact information through the resource mail box so that way it's not broadcast everywhere? Just

use the subject line to be able to pick up that is with the federal employer issue.

(Suzanne Holeg): OK, I will do that and I will also provide contact information of our membership operations folks and our compliance folks and we can all participate in that.

(John Albert): OK, there are other – sorry (inaudible) making this process work for federal (inaudible), thanks.

(Suzanne Holeg): OK, thank you.

Operator: Your next question comes from the line of (Albert Wilson) from Tucker Administrators; your line is now open.

(Albert Wilson): Yes, thank you. My question is I guess to (Pat Ambrose) on the file submission after you have completed your first file the response file comes back and you discover in your system that there needs to be some coverage types changed, meaning you added, add records to first file you may have misquoted family for spouse or something like that (203 or 302). Now the second file with corrections, am I to understand that the corrections cannot be in the same file as new adds, they have to be two separate files, one precedes the other?

(Pat Ambrose): No you can submit them in the same file. What you need to do is go back to or review the event table that's in the user guide and it's a matter of first off is the field that you need to correct is that the key field or the one that is critical to determining MSP and those fields are listed there in the event table. If the original record you submitted, the original add record that you submitted had incorrect information but was accepted, it's important that you also note whether it was accepted with a 01 disposition code. If it was rejected for errors you don't have anything to delete or change but let's assume that it was accepted you got a 01 disposition code and then you realize that I submitted an incorrect coverage type for example and I need to correct that. You would send a delete for the original record and then send an add with the correct coverage type and you can send both of those records in the same file.

(Albert Wilson): OK, I got you.

(Pat Ambrose): Now on the other hand, if it's just a change, you terminate the prior record and with an update, and then send an add with the new information. But that again is if you review that event table it should specify exactly what you need to do.

(Albert Wilson): OK, correct. And then my last question is, I am little confused about the HRA effective date and I think I can probably get unconfused real quick. In the year 2010 if it's not October 1 as an effective date, it's not going to be January 1, 2011 what happens to the effective date between November and December of 2010?

(Pat Ambrose): So you have an example of an HRA that renews on a yearly basis as of November 1 or...

(Albert Wilson): Right, fiscal November 1 that's a...

(Pat Ambrose): Then you may report that but you will report that in your first quarter 2011 file. We cannot accept, it kind of depends on when you are submitting the file quite honestly. We can't accept future date for effective dates but we don't want an effective date prior to one month 2010 and so you may report that if the effective date is 11/1/2010 you may report that in your first quarter 2011 file.

(Albert Wilson): OK, thank you very much.

(Pat Ambrose): You are welcome.

Operator: Your next question comes from the line of (Nicky Henderson) from Health Alliance; your line is now open.

(Nicky Henderson): Hello, I have a couple of questions. One is on our the split entitlement indicator, we submitted a file where we have a member that had an original effective date of 9/1/05 through 3/1/08 and their entitlement reason was B for ESRD and then our second record response record was an MSP with effective date of 3/1/08 to the current with an entitlement reason of A for Aged. But

the second record is coming back as bypassed to us. Like we sent one record showing original effective date of 1/1/09 I think it's probably what we put in there and we got two records back both with the entitlement indicators set to a "Y" but we are not sure what to do with this when the second record is coming back with a reason code of "BY" for bypass.

(Pat Ambrose): Could you give me just a minute, unless someone here knows on the top of their head?

(Phil Ducker): We will have to give (Pat) just a minute I am afraid.

(Nicky Henderson): That's fine. And we have a couple of instance where we are getting those split entitlement records where both of them, on the other situation, both of them are accepted but we sent one record we got two records back which is what we expect, they both being accepted. So, on the next submission we just send one record again, correct as they aged in.

(Pat Ambrose): Going forward are you asking should you just maintain one current record?

(Nicky Henderson): Correct.

(Pat Ambrose): And that is true. That I can answer. Now the "BY" disposition code, I am assuming you did not submit the small employer exception (HICN) number field, so can we rule that out?

(Nicky Henderson): That's true, we did not.

(Pat Ambrose): OK, then the other reason for that is getting the "BY" to the best of my knowledge is as it states in the user guide that the employee status is shown to be on inactive and so but their reason for entitlement is due to age or disability. So basically what I am guessing is that the field 20 on your input record had a value of 2 init indicating that this individual is not covered due to active employment of either themselves or the subscriber. And so the system and the system is looking at the reason for entitlement which changed obviously as of 3/1/08 and so if you got an 01 disposition code on the period of 9/1/05 to 3/1/08 then an MSP occurrence was created there. However, an MSP occurrence was not created for March 1, '08 going forward due to you

reporting them as being covered or not being covered due to current employment and they have aged in to the system.

So in another words, I would call them a retiree and but you know not necessarily real accurate language but basically you are telling us that they are not covered due to active employment and we can see that as of 3/1/08 they are entitled to Medicare due to their age.

Male: There may be an issue here, I am going to have to talk to (Pat) about the issue is the coordination period under the ESRD provision will continue past age 65 that the individual became eligible based on ESRD prior to attainment of that age. So there may be something that we have to tweak in the system. Our system will now report that the person is entitled now on the basis of age but the ESRD coordination period will continue because it was started prior. So we may have to worry about that and thank you for calling that to our attention. If you could, if that's described in detail in one of the questions going to the resource mail box? Have you submitted that?

(Nicky Henderson): I have not. I have not; we just went back to our file this morning to make sure we have all of our questions, so I didn't submit it in. But I can.

Male: If you can submit that in the mailbox and indicate in the header someplace that it's for ESRD eligibility transitioning to aged eligibility that will be the trigger for us to look at that.

(Nicky Henderson): OK.

(Pat Ambrose): OK, so it sounds like a system is working according to the user guide but there is a problem with that. So (inaudible) and we will take a look and see what we need to do.

(Nicky Henderson): And I have one last question, we have a situation where we had an eligibility date was – oh trying to explain here pretty well – the effective in term date in what we are sending was 1/5/09 so the coverage ended on 1/5/09 and new coverage started on 1/5/09 so when we send that in, when we send the term date, the problem is that our effective in term dates are the same dates

because we are saying that the first of the year, first of '09, it's not a 30 day span, does that make sense?

Male: I think part of what you should be doing if a coverage terminated on midnight or 11.59.59 on the fourth you should be reporting the fourth as the term date and the new begin date as the fifth effectively 12 midnight... '01.

(Nicky Henderson): OK, let me rephrase my problem, I am getting an SP 32 on there which says it's an invalid term date which they said the start and end dates need to be 30 days apart. So I have this person who the MSP effective in term date sent on the reply was 2009 – 01/05/2009, but the termination date is not greater than 30 days for the MSP effective date because we didn't start the process until 1/5 of '09.

(Pat Ambrose): Yes, I am having a little trouble, I am sorry completely understanding your scenario. What I am going to suggest is that you submit this question to your EDI representative but also take a look at the user guide and see where we do address situations where the coverage that you are reporting is less than 30 days. And it basically is saying that if, let me see if I understand the situation, you have a coverage starting 1/1/09 but then changed on 1/5/09 and 1/5/09 going forward it was something else and you are trying to report that in two records?

(Nicky Henderson): It was a spouse, a subscriber's spouse situation. So when the spouse was terminated on 1/5/09 but we didn't begin sending our coverages until 1/1/09 so we are sending the spouse we have to send an add for the spouse and then a term, right? Because she was effective from 1/1/09 to 1/5/09.

Male: For 5 days.

(Nicky Henderson): Yes, for 5 days.

(Pat Ambrose): Yes, that's covered in the user guide where it basically is saying just send one record with the most recent information to reflect the coverage going forward subsequent and pretend then in a sense that coverage was always sustained in those 5 days. Your other choice would be to only submit one record with 1/5 as the effective date going forward and forget about the five days.

(Nicky Henderson): OK.

(Pat Ambrose): Well, (Bill) doesn't want you to forget the five days. So submit, so this is the recommendation in the user guide for SP 32 in this particular less than 30 day issue.

(Nicky Henderson): Yes, and that's what we are just going to resend the record I think on our next transmission and hopefully that will fix that error.

(Pat Ambrose): Yes.

(Nicky Henderson): I did talk to my EDI representative on that and he said, well I don't know.

(Pat Ambrose): I will make sure he does know.

(Nicky Henderson): He doesn't like me, so that's OK.

(Pat Ambrose): Oh, no, they are...

(Nicky Henderson): Thank you very much, that's all I had.

(Pat Ambrose): OK.

Operator: Your next question comes from the line of (Sue Hellenbrand) from (End of the Health Insurance); your line is now open.

(Tammi Meyer): Hi my name is (Tammi Meyer) with Unity, the question I have is in regards to the TIN compliance codes of 02. I guess we are getting a little confused with all here, because our EDI rep is telling us that if we get this code back we need to resubmit the records but based on the conversation earlier on the call it says that we need to have the TIN as valid and then resubmit it as soon as possible.

(Pat Ambrose): Here's what you need to do. You need to provide supporting documentation to your EDI representative to demonstrate that the TIN is valid. They will then update the system, the section, the (CLBC) section 111 system with the fact that TIN is indeed valid. And then your next quarterly file submission

when you submit that TIN. I mean the record has been processed and it is on file. You don't need to resubmit all of those records they were accepted and they were processed and we did in fact store the TIN information. So to the best of my knowledge there is no need to resend all those records. The point is the next time you do send the record with that TIN you should not receive the compliance flag again.

(Tammi Meyer): OK, but when we submitted them back in July we got a response file in October and they errored for that reason and then again we got the response file back in January and they received the same error again.

(Pat Ambrose): Now, did you supply your EDI representative with the supporting information to indicate that TIN is valid or it doesn't happen automatically.

(Tammi Meyer): Well, I asked the EDI rep what we are supposed to supply for...

(Pat Ambrose): Alright, we will get all that cleared up. And so again we will make sure that the process is understood and you should be able to get your rep to update that. Can I have your RREID please?

(Tammi Meyer): Yes, 0627.

(Pat Ambrose): I am sorry, could you say that again?

(Tammi Meyer): 10627.

(Pat Ambrose): OK.

(Tammi Meyer): The other question I had was in regards to query only files. How reliable is the Medicare (AMB) entitlement dates? The reason I ask is because we are getting for example a member that has ESRD of 1983 and it says the reason for entitlement is still ESRD, I guess I am still unsure if it still have that? Does that make sense that they...

Male: You could become entitled on the basis to be ESRD you would remain in the system as ESRD, unless you had a successful transplant until such time you would become entitled under the basis of age or disability.

(Tammi Meyer): They could have it for 25 years of ESRD?

Male: Correct.

(Tammi Meyer): OK, the other question in regard that is we had a member had on the 11/9 query file it says they had age was the reason for Medicare part A & B as of 8/1/03 and then on our 12/9 file it says that disability as the reason for the same date of 8/1/03. So would that have changed?

Male: Generally you are not going to go from age to disability. We are going to...

(Pat Ambrose): I think they submitted the question.

Male: Is that a submitted question?

(Tammi Meyer): I just submit that, yes, yesterday.

Male: OK, we will have to...

(Phil Ducker): I saw it.

Male: OK, we are going to have to look it; you have got contact information on that?

(Phil Ducker): Yes, they have the email address.

Male: Because generally you wouldn't go from age to disability, unless there was some error in our reporting age.

(Pat Ambrose): That could be some kind of correction that was made under the myriad of different possibilities. You should not be seeing that particular information changing. So we are not sure what's up with that. And yes, the query information is reliable, to answer that. Could there be issues with the Medicare beneficiary database that we use. Of course, every system has issues and corrections are made and so on and so forth. But you know the information that (CLBC) has regarding Medicare entitlements and enrollments and those corresponding dates and reasons for entitlements are reliable.

(Tammi Meyer): OK, so if a person had Medicare for age and disability, will we get two responses back on the query file?

(Pat Ambrose): It's only possible to have one reason at a time.

(Tammi Meyer): OK. Alright, then I will get an email back in regards to that first, the issue we just talked about?

(Pat Ambrose): Yes, we will follow-up with you on that. I have your EID as well.

(Tammi Meyer): Alright, thank you very much.

(Phil Ducker): Operator, operator we are going to go offline just for a second, about 15 seconds we will be right back.

(Phil Ducker): OK, operator we are back, thank you very much.

Operator: Not a problem, your next question comes from the line of (Helen Moyer) from Guardian Life Insurance; your line is now open.

(Helen Moyer): Hi, my question has to do with the recent user guide release, and referencing of appendix I, I just wanted to understand, make sure that we understand correctly the date of the employer size change that you are asking us to report on our input file. So for example, if an employer size category was less than 20 in calendar year 2009 and they become an employee size category of 100 plus on June 1st of 2010, we would report an employer size change for working age as of June 1st 2010 and for a person who is entitled to due to disability for a January 1, 2011.

(Pat Ambrose): No, that's not quite correct. You know the employer size for the particular (GHP) that you are reporting is the same for everybody regardless of their entitlement. The reason that appendix is talking about disability versus working age is because Medicare rules and the calculation of employer size was written unfortunately by reason for entitlement. So I would say is again for everybody that you are reporting in a particular GHP it's all for one employer and that employer has only one size. And try to go through that decision tree so to speak that was given to you that as of, as you are reporting

as of January 1st, is this true then set the employer size to that, is that true then the employer size to that, and so on. And then of course during the course of the year you need to track whether they have more than 20 employees for more than 20 weeks within that current calendar year because that relies on the prior occurrence but you do not report employer size by reason for entitlement for each individual.

(Helen Moyer): OK, and so in the example I kind of ran through would we report that then based on the earliest employer size change so for that example it would have been June 1, 2010?

(Pat Ambrose): You know I am not really comfortable going down into the weeds, I know I should but I am afraid I might miss speak. So what I would ask you to do is, after reviewing that user guide appendix, if you have further question submit it to your EDI representative and I would be happy to help them answer it for you. You may also submit it to the section 111 website and also note that we are creating computer based training modules that will be released very, very soon. They are under the final review and they will probably help a lot as well too to explain it. But you know given the amount of time that we have on this call and you know my fear that I might get myself confused while on the spot because it's a complicated topic, I would really rather not answer it for you right now.

(Helen Moyer): I think it's very important that you do make it clear in your examples because I am sure there are companies that don't always attend the teleconferences and...

(Pat Ambrose): Right, exactly, so if you could submit this question and if it's determined that an additional example is needed in that appendix we will be happy to add it and possibly cover it when I am properly prepared so if that is your last question I would like to go on. You know please submit it, it will be answered but I will like to move, because I am not prepared to get down into the weeds of the employer size calculation right now.

(John Albert): This is (John), based on the information that was published recently in the guide again for comments on that section please submit them as (Pat)

mentioned we are about to wrap up the training that we are going to release for this particular topic which is obviously a great interest to a lot of people because it is you know a rather difficult process to wade through but again please for anyone out there that have comments get them to us sooner than later because we are getting ready to release this training module out there for everyone that will be helpful to allow you to engage for considerable amount of time this topic on this one topic on the computer based training module.

(Pat Ambrose): And again can you give me your RREID and I will make sure that we get back to you on your specific question? Are you still there caller?

Operator: I am sorry, is she able to press star one again?

(Pat Ambrose): Well, that's alright, I am sure they will get to us, no matter. You can go on to the next question, thank you.

Operator: Your next question comes from the line of (Shellie Matthis) from CIGNA; your line is now open.

(Shellie Matthis): Yes, thank you. I have two questions on HRAs. First with regards to the $1,000 threshold, is that referring to the amount the employer funds the HRA for the year? Or does it include any carryover of unused funds from prior years? For example if the employer funds the HRA with $750 for the year, that wouldn't be reportable but if the employee carries over $300 from the prior year's unused HRA balance putting them over $1,000 of available funds is that now reportable in that second year?

(Phil Ducker): If the value of the HRA at the beginning of the reporting period over a $1,000 then it's reportable.

(Shellie Matthis): OK, we have HRA products that are currently available to the employee. For example, we have a retirement HRA that accumulates funds annually but is not available to pay expenses until the employee retires. I assume you do not want us to report on that until the employee actually retires and has access to those funds.

Male: Well, be careful because you are only reporting on active covered individuals on your MSP input file. So if they are retiree with a coverage and not ESRD then you are not reporting them.

(Shellie Matthis): Yes, that's true, that was a poor example. We have others like the suspended HRAs that are suspended while the person has an HSA coverage and so then later that might become accessible, so that wouldn't get reported until they actually have access those funds.

Male: That's right.

(Shellie Matthis): OK, thank you, that's it.

Operator: Your next question comes from the line of (Jane Straub) from Sutton Bank; your line is now open.

(Jane Straub): Hi, I got a question about reporting for the first time about HRA. I understand we report data on that we start accumulating from January 1st, 2011 to obviously March 31st, 2011 so that means my first submission will be within my submission timeframe in the second quarter of 2011 correct?

(Phil Ducker): Yes, as far as we can tell.

(Jane Straub): OK, then the other question is about that annual benefit, that $1,000. Again if the summary plan doc or the plan doc says that a participant could have a $2,400 out of pocket reimbursement regardless of that participant was actually paid that amount of money, I mean I guess my question is we reimburse on a monthly basis, so if I have participant who had $100 and I reimburse them on that $100 at that point do I start reporting that individual?

Male: You start reporting when the HRA is established and has an effective date.

(Phil Ducker): It's not the payout or the payment date that's reportable, it's the coverage when the benefit began. Think about it just like an insurance policy from BlueCross plan, when it becomes available to the employee that's the beginning when the activity can be reported and that's your establishment date your first report date.

(Jane Straub): OK, alright. And then I have been actually, I am one of the those small employers that actually administers their own HRAs, but I am actually interviewing PPAs so that way I can become, be compliant with the reporting mechanism, and I have gotten a lot of people pushing back saying that my plan is disconnected to Group Health Plan because obviously that's we operate it, we have a high deductible plan and so to offset that we do the reimbursement and I keep getting pushback saying our plan probably does not have to report because if they are a member of the Group Health Plan then they are automatically enrolled in the HRA, that's not true correct? I mean if my plan designed is not an HRA but I administer an HRA on the side because it is a high deductible plan...

(Phil Ducker): Really we can't answer that question, are they automatically enrolled in the HRA, that's up to however you setup your insurance coverage. I think the pushback is probably coming from you have to be in GHP before you can get the HRA is that right?

(Jane Straub): Right and they are saying that in that case it's not a free standing plan.

Male: But it is still embedded.

(Phil Ducker): Yes, it sounds like it could be an embedded plan, an embedded HRA to us but even though it may be embedded it may have to be reported separately that is your GHP. Insurer may not be reporting it because it may not be actually managing it let me put it that way. If it's not managing that HRA then whoever is managing that HRA will have to do the reporting for it.

(Jane Straub): OK, thank you.

Operator: Your next question comes from the line of (Denise Steelwall) from Paramount; your line is now open.

(Denise Steelwall): Yes, I thought I remembered hearing on the last call that when we receive a response file back they were updating like the (burst) state and that stuff that was not correct in our system and I thought that was no longer going to be happening, do you remember, is that correct and if so when is that going to start?

(Pat Ambrose): We will always (inaudible) that, the current user guide does document on both the query response and the MSP input response as well as the non-MSP, what we provide back as far as Medicare's current information is, what we are not doing and one time were but no longer sending you back an updated or changed or different SSN that you might submit. So we always send you the most current (HICN) number we have on file, Medicare ID and information related to name, date of birth and gender, of course you have to have matched three out of four of those anyway. So most likely the information is not going to differ too much from what you already have in your system. But what we, those fields we will send back what Medicare has on as the most current information for those fields. But the SSN we do not, maybe that's where what you heard.

(Denise Steelwall): OK, that might be it. I have put a call, I have sent an email to the resource mailbox requesting the call transcripts which is what I thought you guys said to do and I received an email back saying it will be posted on the website but I still haven't seen them, so that's why I was trying to look up the information there but I couldn't find it. Another question, the status of the 271 and 272 companion guide do you know what the status on that is, when it is supposed to be posted?

(Pat Ambrose): To include the DCN field, that update.

(Denise Steelwall): Yes.

(Pat Ambrose): I don't have the, as far as I know it is very close to being completed, it might be in the queue for posting, I will have to follow-up on it. But the alert on the alert page on the website does, should provide you with what you need for the mapping.

(Denise Steelwall): OK, I found the alert page and I have passed that on to the programmer but we were having trouble with our last 270 file and we kept getting some kind of conflicting information based on what was in the last companion guide and what we have been sending and now it looks like this time we have been sending multiple (STSE) segments and transactions and it looks like on the last query file we got back that they possibly only processed the first STSE

combination. So file that we sent was huge but we only received back 98 responses, so...

(Pat Ambrose): That doesn't sound quite right, could I have your RREID?

(Denise Steelwall): 10516.

(Pat Ambrose): OK, we will have somebody follow-up with you.

(Denise Steelwall): Can I ask one more real quick question?

(Pat Ambrose): Sure.

(Denise Steelwall): Does a member need to be eligible for both A & B or just one of the other or is it only A?

Male: Under the GHP rules, it's the eligibility based on having paid your (inaudible) FICA taxes for A only.

(Denise Steelwall): OK.

Male: So the individual can have A only or A & B or B only does not trigger the GHP provisions.

(Denise Steelwall): OK, thank you very much.

(Pat Ambrose): OK, thanks.

Operator: Your next question comes from the line of (Susan Seeker) from Benefits Design Group, your line is open.

(Susan Seeker): My question is related to HRAs, if you have a plan design where there is basically three different HRA buckets. Single people get $500 to help them pay their deductible, employees with just a spouse get a $1,000 and then those that have a family with two or more people included in the family get $1,500. You have got some people that fall under the $1,000 threshold and some people that might fall over, do you have actually pick out the people that are

in excess of $1,000 possible reimbursement and only report those people and the rest of them you would not include in your file?

(Phil Ducker): That's correct, only have those people who have over $1,000 available to them are Medicare beneficiaries.

(Susan Seeker): OK and one other quick question. If you have an HRA that's a free standing HRA that an employee can get $2,000 worth of reimbursement in a year but by definition the plan reimburses any section 213(d) expense which basically wide open you can use it for dental and vision and medical, some of those things would be Medicare eligible expenses and some of those would not, just because they go over the $1,000 would have to report them even though you had possibly have turned in only $2,000 worth of dental expenses?

Male: You would need to report the fact that it had $2,000 of benefits were expended, then you would in... (Inaudible).

(Pat Ambrose): It would be reported, it does technically meet the threshold, even though some of those benefits are not covered by Medicare and that will have to get sorted out in the claims payment.

Male: That will all get sorted out downstream in the claims processing, it's obvious that there may be bills submitted to that relate to that HRA coverage if the coverage is exhausted that is the claims processing issue not a reporting issue.

(Susan Seeker): OK, thank you.

Male: Paid for services not covered by Medicare (inaudible).

(Phil Ducker): Operator we have got about three minutes to go, how many more do we have in the queue for questions.

Operator: There are approximately nine people in queue.

(Phil Ducker): OK, let's take two more questions and then we have to close it off.

Operator: Certainly, your next question comes from (Steve Venisfinger); (inaudible) your line is open.

(Steve Venisfinger): Thanks for taking my phone call, my question will be direct in the form of an example and answer that. This relates an HRA. Employer purchases a BlueCross and BlueShield plan with a $2,500 deductible, in this case BlueCross' RRE. Employee sees an underlying deductible of $500 with the employer properly setting up a self-administered, self-funded HRA with potential to reimburse up to $2,000 well above the $1,000 safe harbor. Will the employer need to report necessary section 111 information?

Male: You setup the HRA in the amount of excess of $1,000 correct?

(Steve Venisfinger): It's up to $2,000 in the example, yes.

Male: Right, so if it's reported.

Male: I mean if the employer subsidizes and administers it then yes.

(Pat Ambrose): Yes, be careful about defining who the RRE for the HRA is, if there is a claims processing TPA they report but if the employer is self-administered then they would technically be RRE and have to report.

(Steve Venisfinger): Even though the HRA participants are an exact match to the BlueCross and BlueShield participants?

(Pat Ambrose): That's what we have said, yes.

(Steve Venisfinger): It seems redundant.

(Pat Ambrose): Well, it is possible to have people with multiple insurance coverage and we are coordinating benefits of all these insurance coverage's with Medicare. So very often do get reports of multiple insurance coverage and this is just another example of that.

(Steve Venisfinger): Of the redundancy?

Male: It's not necessarily redundancy; both plans are primary payers to Medicare.

(Pat Ambrose): In another words, the claim may need to got both of those primary payers prior to coming to Medicare, so it's not really redundant in the sense, in that same sense.

(Steve Venisfinger): OK, thank you.

Operator: Your next question comes from the line of (Rich Gloss), from (inaudible); your line is now open.

(Rich Gloss): Thank you just to reiterate, if the employer bundles up its HRA and its medical plan to where you have to be in the medical plan in order to be an HAR but chooses a different administrator for each of those, that HRA would not be considered a free standing HRA is that correct?

(Phil Ducker): No, the HRA would be considered, well it's different administrators for both?

(Rich Gloss): Yes, so the insurance career administers the claim under the medical plan but they use the TPA the HRA, they bundle the two together and many people would consider that to be the embedded plan, that you got two different claims administrators is that free standing or not free standing?

(Phil Ducker): It's either an embedded HRA or not, it sounds like with two different administrators it is not an embedded HRA and the fact that of the matter is that it still going to have to be reported to us in any case so whoever is doing the reporting is going to have to make those sorts of arrangements to do that.

(Rich Gloss): OK, a dental only HRA, an HRA that only reimburses dental insurance premiums...

(Phil Ducker): Dental is not a Medicare covered benefit.

(Rich Gloss): What?

(Phil Ducker): Dental is not a Medicare covered benefit.

(Rich Gloss): Right, so an HRA only reimburses only insurance premiums so those would not be reportable.

Male: No, that's correct; we need an HRA that only reimburses insurance premium.

(Rich Gloss): But an HRA can be setup to reimburse individual insurance premiums and some employers that's all they offer, is a mechanism whereby they can help fund individual insurance premiums. Will that be reportable?

Male: You have got other issues involved there I would that you explain that in more detail into the resource mailbox.

(Rich Gloss): OK, and finally just to clarify if my understanding is that just about all of our HRAs have a calendar plan year that starts in January 1st and maybe we only have one or two with a fiscal year plan that starts on October 1st, we only need to report in our first fourth quarter those October 1st effective dates, right?

(Phil Ducker): That's right.

(Rich Gloss): OK, thank you very much.

(Phil Ducker): OK, thank you. Operator, we are done. Can you tell how many people we had on the call?

Operator: Yes, we had a total of 220.

(Phil Ducker): Thank you.

Operator: You are welcome.

(Phil Ducker): OK, we are done, thank you operator.

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

END