TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
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DATE OF CALL: May 14, 2009

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Question and Answer Session.

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FTS-HHS HCFA

Moderator: John Albert
May 14, 2009
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. To ask a question during the question and answer session please press star 1 on your touchtone phone.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

I would now like to turn the call over to your host for today, Bill Decker. Sir you may begin.

William Decker: Thank you very much operator. Hi everybody. My name is Bill Decker.

I'm with CMS in Baltimore, Maryland. It's 1 o'clock in the afternoon here on the East Coast on this Thursday.

This is a non-group health plan call - NGHP only. If you're a group health plan person there's a call for you next - or later this month I guess. But in any case this is not a GHP call at all. This is an NGHP call.

Today's call is going to be opened to as advertised what we are calling policy questions. We had a call two days ago that was focused on registration and other technical questions.

And that went very well. We want to remind everyone that if you can focus your questions today on general policy so that we can go - we can describe to

you what we think about this process and how we believe you should be reacting to this process that will make more - that will speed us along here.

We're going to do a relatively brief opening I think; probably briefer than we usually have on these calls. And then we're going to turn it over to you folks out there for any of your questions.

We do have one caveat that we would prefer if you could ask one question and then at most one follow-up question and then leave us from the - leave the call and if you have more questions as they might occur to you later you can get back in the queue. And if we can get through all the questions we'll get to your next set.

But please try to limit yourselves to one question and one follow-up because there are lots of folks on these calls and they have lots of questions and we'd like to try to get to them all.

With that I will turn it obvert to John Albert who I think has some - wants to say a few things before we get started. And then we'll...

Barbara Wright: Or he may not wish...

William Decker: Or you may not. And then we'll turn it over to Barbara Wright.

John Albert: Actually we're going to - I'm just going to turn it over to Barbara since I had to step out a second so I'm not sure what Bill told you.

Barbara Wright: The first thing I wanted to mention is the quick registration reference. We talked about it on the call on Tuesday but it wasn't available online because we were having some problems with our system.

That quick registration reference guide is up. One problem though is if you go to the What's New Page if you scroll to the bottom of that the old version that we were having problems with is still there. You need to go to either the NGHP page or the GHP page. It will be on at least one of those two and be downloadable. It is the same reference guide for both GHP and non-GHP. So that is available now.

The second document that we talked about just went over briefly and is now up is an alert that changes the implementation timeline for NGHP. And I wanted to go briefly through that for those of you that may not have seen it yet. It is now available on the website.

The first thing in the alert is that we've extended the registration period for NGHP through September 30. You still can register now. We would prefer that you register as soon as possible but you do have until September 30.

And as we put in the user guide if you don't have a reasonable expectation of having anything to report you don't need to register at all right now. You do need to keep an eye on the situation and then once - if you would have a situation in the future with a reasonable expectation of possible reporting we would expect you to register in time to allow a full 90 days for testing before your expected report.

The second item on this alert is that there is a change in the testing period for the claim input file and in the start date for the live production submission of the claim input file. You now must submit your first live production file in the April through June calendar quarter of 2010.

The testing for the claim input file will now take place January 1 through March 31 of 2010. Once the testing is complete if you complete it early enough in that quarter you may submit a production file in that order if your submission date has not already gone by. But you are required to submit by the quarter starting with April.

Let's see. The query function which all of you have expressed great interest in - the query function will be available to you as of July 1 if you've registered by that date. In order to use the query function you will have to have completed registration and be in testing status.

What puts you in testing status is once you register and you've received the profile report that needs signed by the authorized representative that is signed and has been returned and received by CMS's coordination of benefits contractor.

They will then put the RRE in testing status. Both test query input files and production query input files will be accepted and processed for an RRE ID that is in testing status.

Also just to repeat again you won't be able to use this function unless you've completed registration. So if you decide to delay until September 30 to register that's fine. Just know that you're not going to be able to start your query unction till then.

We also have a new exception regarding TPOC reporting dates and reporting for multiple TPOC amounts. We have decided in conjunction with the extension or delay for the initial report that the section 111 reporting will not include TPOC amounts with TPOC dates that are prior to January 1, 2010. As you know the date before was July 1, 2009.

You should keep in mind though that the dates associated with the reporting of ORM have not changed.

If you have TPOC amounts that are dated on or after January 1, 2010 and they fall below the threshold amount you must add all associated TPOC amounts dated on or after January 1, 2010 to determine whether or not the threshold amount. Any associated TPOC occurring prior to January 1, 2010 is not considered when you're calculating the threshold.

When you have a combination of below threshold amounts or a final one that brings it over the threshold on or after January 1, 2010 we will determine timeliness based on the applicable date for the TPOCs which caused the threshold to be missed.

So you don't need to worry about the fact the your first TPOCs - let's say you have three TPOCs before it went above the threshold. And two of them were in the first quarter when you had to report. The third one was in the second quarter. Whatever the submission date is for that third TPOC would be the one that would control timeliness for all three.

And we in the alert that we put out earlier about reporting multiple TPOCs that essentially lays out the specific steps. So just to repeat the dates again it's May 1 through September 30 for registration. It's July 1 when you can start test and production query input files if you have registered and are in test status. It's January 1, 2010 when you start testing for claim input files.

It's January 1, 2010 for when production claim input files may be submitted if you've completed testing and your submission window hasn't bypassed yet.

And it's April 1, 2010 through June 30 that you must submit your first live production file.

Another document that's on our website or will be shortly is we have revised the implementation timeline that was on the overview tab. And is that up yet? Okay. It's in the queue to be put up but it's not actually on the website yet.

We're continuing to get questions about a model form. We are close to getting the model form for GHP out which is of course already reporting though it has to be our first priority. There will be a separate form for NGHP. You should not assume that you can use the GHP form. We do expect there will be some differences so you need to wait for the NGHP form.

In terms of other issues that we're looking at we expect with probably about the next two weeks we expect to be talking to various folks in the industry about issues surrounding bankruptcy and litigation so we can get something out on that. We're still planning the sessions on mass torts and product liability. Language related to clinical trials is in process. And we're looking at foreign address issues as we received several comments on that recently.

Okay.

I wanted to quickly go through a few of the questions that came in. We - John said on the last call on Tuesday that we had hundreds of questions. We actually have thousands of questions. And we've gotten pages and pages in the last few days so I'm going to go through a few but we do want to give preference to you asking questions.

So some of the ones that came in - people are asking about the funding delay and they wanted to know exactly when that's reported. And the funding delay

field is only reported if the start of the funding is delayed. It's not reported in a situation for example where a TPOC - the actual payout is through a structured settlement and there is some delay in when that starts. Then you would report delayed funding. But it's not considered delayed funding just because some of the payments are not made all at the same time.

We've also received questions about deducting attorney fees and costs from TPOC amounts. This is not something you do. We need the full TPOC amount where there is any reduction appropriate in connection with the recovery claim. That's part of our process.

We've had several more questions about just JPAs in general. And again - joint power authorities. In the user guide if you meet the criteria that are in the user guide then the JPA is the RRE.

We had questions about documentation for termination of ORM. And we were asked whether or not a standard discharge report was enough. And that description is not sufficient for us to give you a yes or no answer. If it's a discharge report that's indicating the person needs no more treatment for the condition or for the alleged injury that's fine.

But if it's just a discharge report from one physician saying, you know, not indicating there's no more care for the particular illness or injury but that there's no more need for that particular physician's services that's not necessarily enough.

If you have a surgeon his work may be done within a week or two weeks. But that doesn't necessarily mean the person's not getting ongoing care. We were asked about again with ORM the ongoing responsibility to medical - there

seems to be some confusion about TPOC amounts connected to ongoing responsibility for medical.

As we said in the user guide the TPOC amount is calculated and determined without consideration of ORM. If you have an ORM situation that terminates you do not report the sum of the OR payments as a TPOC amount. We don't ask for the specific amounts that are paid within that ongoing ORM.

With respect to pooled fund members we were asked if the criteria are met but if - but they also have some members that are ASO members - just administrative services only members that simply have the pool process the claim can the pool be the RRE for those ASO members? And our answer on that is no.

We had a question asserting - I think we had one earlier but we have one about saying the links the we've listed in our file layout for ICD9 are wrong; supposedly that ICD9 - ICD10 is now being used. But we did double check the links again and they are working when we checked them. And CMS is not using ICD9 at this point.

I'm mixing up the numbers - I'm sorry.

We're using ICD9 - links worked for ICD9. We are not using ICD10 and we will announce at a future date when we wish to switch to ICD10.

We had questions about the qualified exception for ORM.

And in connection with that I'll give you an example. ORM was assumed in 2007. The RRE had under its standard practices and rules closed that record

prior to 1-1-09. But they still have technical responsibility because they are for example in a state where medicals are lifetime.

In that situation where it was closed before 1-1-09 they don't have to report it as long as there's no further action. If it's reopened at some point then they would report it as a new record.

Same situation - ORM was assumed in 2007 and it's still open on their records under their rules and procedures it was opened. They do have to report it.

Third situation it's in their records even if under their standard rules or procedures it would be closed if they have technical responsibility and they assumed that ORM - if it was open on or after 1-1-09 they do have to report that.

Again you have the additional exception if you have the physician statement that no further treatment is needed. If you have any other basis such as that or statute of limitations removes responsibility or state statute says all responsibility ceases after X point all of those would be valid reasons to terminate the ORM. This exception is only dealing with cases where you would technically be responsible under our rules because it wasn't closed under any state rules.

We've had several questions just recently about biweekly wage loss reimbursements under worker's compensation and how would these be reported because arguably it would be approximately seven TPOCs per quarter. We are looking at this issue and hope to get back to you on it shortly.

We had another question about structured settlements where the minimum payout is zero. In that situation how do you calculate the TPOC amount? And

we went back and looked at our language again and what we've said is that you have to report the minimum payout or what would be the - you have to base it on the time period used in calculating the cost for the annuity.

In other words if the cost for the annuity was based on 23 years then use 23 years. If the cost of the annuity was based on two years use two years.

Two or three of the questions tried to tie ORM to future medical beyond any TPOC date and beyond the ORM. ORM is not used in connection with TPOC. It's not used in terms of a final future payment under a structured settlement was part of the wording on this question.

ORM is used when the RRE has responsibility - current ongoing responsibility where you're actually getting bills, having them submitted, paying those bills, et cetera. So you should not be thinking of it in terms of future TPOCs.

We continue to get a few questions where people are asking about TPOC amounts and turnaround and say, "We would be paying these six medical bills." or, "We would be paying these 20 medical bills." We are going to need more input from you to understand your position on this. Everything in this type of question is indicating to us that these are situations where whether it's for the short term or not at least for the current term the RRE has actually assumed ongoing responsibility for medical.

We were asked about in no fault does the RRE have to include the amount of each bill and the payment and the explanation, the balance. And our expectation for no fault is that generally no fault is going to be reported as ORM until it's exhausted at which point you won't have any - until it's exhausted or you have evidence that there'll be no further treatment expected.

We don't see this as one where you would be having individual bills paid other than under ORM. Certainly you may have TPOC in some situations for no fault.

I'm going to have to ask John about this one. We had one question come in that was mentioning that social security has a social security number verification service to verify claimant's SSNs. And this is a free service by social security and they wanted to know if they could use this in connection with section 111.

In general we're said that you can't use other systems or other access you have specifically for 111 if you don't have a right to otherwise use them. The question - the submitter of this question specifically said apparently this service although employers can use it it is specifically limited to verification of employee social security numbers.

So from our perceptive we know of no information that would allow you to use it to check anyone other than an employee that you're already doing for other purposes.

You have any other thoughts, John?

John Albert: No I mean it's - I mean that pretty much depends on what that agreement if you use that service with SSA would be covered. And we have no authority over Social Security Administration in terms of driving what that process is for. I'm not even sure what that was set up for.

But they would have their own basically data use agreement to obtain that information or verify that information and you would have to abide by that agreement.

Barbara Wright: Okay.

We're also continuing to get some questions that seem to be trying to pull in other instructions as being automatically applicable to the section 111 reporting. The one we see most often is where someone wants to talk about the workload threshold that's currently used for purposes of worker's compensation, Medicare set aside amount request for CMS review. And they wanted to say can we assume the same thresholds apply for section 111?

The answer is no. For section 111 reporting you absolutely need to go to our dedicated web page and use instructions there. Instructions for other parts of the MSP procedures simply don't apply.

ICD9 information, coding information, several questions phrased their inquiry in terms of our TPA is not provided with ICD9 informality by such and such date. Or we have not yet obtained ICD9 information so how can we report this at this point in time?

Keep in mind that we are not saying that you have to obtain ICD9 information on a medical record. You should be reporting ICD9 information related to what the alleged injury is.

So it's perfectly fine with us that you develop your own expertise in terms of assigning ICD9 codes. You can't control your timing or assume that only - that the medical record will necessarily cover everything, particularly as several of you have indicated in liability situations things may be alleged as what you call a nuisance suit.

If they're alleging a particular harm whether or not they're any medical records with that particular diagnosis code you should be supplying us with the ICD9 codes related to the alleged harm.

Similar to that I want to ask about an ICD9 code for failure to diagnose. In that situation we wouldn't be looking for an ICD9 code for failure to diagnose. We would be looking for the ICD9 codes related to the medical that would be associated with the harm that's being alleged or the illness or injury connected with the failure to diagnose.

So that we can get started on your questions want to go through some things on responsible reporting entities. What we're looking at doing right now is hopefully getting a list of examples together and a draft distributed on the website to everyone within a couple of weeks and then specifically asking for comments on specific examples.

If you have a problem with it, if you don't understand it so that we can get consensus to the extent possible or certainly make sure that we're using terms that everybody is familiar with. Just recently we had one entity submit his list of - it's a whole page of terms that they believe cloud this issue.

And so what we're going to try and do is come up with examples that can be read through - sort of through the lens of any of these terms. What we can say for purposes of this right now is under current plans if you've got a policy with a deductible and the deductible amount is considered self insurance if the policyholder pays hat deductible to the injured party or pays it on behalf of the injured party and the insurer pays any amount above the deductible then the insured is the RRE for the deductible amount. The insurer is the amount - is the RRE for the amount above the deductible.

The second scenario we've already put out in writing is if you have the same situation of a deductible but the deductible is paid to the insurer by the policyholder then the insurer will be the RRE for both the deductible amount and for the amount above the deductible.

What we will try and do in the example is refine the term "paid" better. Because we're getting a lot of questions where TPAs are inserted in this whole process and in many of the questions there is no designation of whose TPA it is. So if it's a TPA of the policyholder that might generate different results than if it's a TPA of the insurer.

The third thing we're looking at and want to give consideration to is it follows along the same line of the second one where we said if the deductible is paid to the insurer rather than to the injured party that by having the insurer report both it cuts down on reporting.

What we're considering is if we have a situation where there is an amount paid above the deductible that in that situation the insurer would always be the RRE because they would already have a section 111 reporting obligation. And the fact that they would - and since they wouldn't be making payments unless and until they knew that the deductible needed to be paid or had been paid they would simply report the total of the two.

So we're looking at that and that would cut reporting down and would help also eliminate a large - potentially a larger number of RREs that are only responsible for deductibles.

Before we go to your questions - I think the general rules I gave you cover most of what we were talking about before we do the examples. As an example of how TPAs play out in this is if you're giving as an example in a

comment or you're commenting on something let's say there's a large deductible program.

And the insured has a third party administrator and they actually fund the loss. In that case they would remain the RRE. Take the same comment coming in and the reference to a third party administrator was really referring to a third party administrator of the insurer to whom they submitted funds then in that case under what we have right now the insurer would end up being the RRE.

So if you give us further examples or you comment you need to be very specific about what role any entity you're talking about is taking.

And I guess Bill do you have any questions or comment before we open it up for questions?

Operator?

Coordinator: We will now begin the question and answer session.

If you would like to ask a question please press star 1 and record your name. To withdraw your question press star 2.

Again to ask a question please press star 1 and record your name.

One moment please.

Your first question comes from Darryl Brown, Sedgwick CMS.

Darryl Brown: Hi good afternoon. This is Darryl Brown. Barbara I have a question regarding what you just sent regarding large deductible programs where the insured has a TPA. And the TPA is funding the loss or paying the losses.

In that case if it is the deductible program that's actually paying the losses if the deductible insured that is the RRE. Is that correct?

Barbara Wright: What I was referencing - the example I gave was where we were only talking about the deductible and the insured had a TPA that it used for purposes of paying those deductibles on its behalf to the injured party.

The insured would be the RRE for that deductible portion.

Darryl Brown: Okay. Thank you.

Coordinator: Your next question comes from (Jeffrey Haynes), Sedgwick CMS.

(Jeffrey Haynes): Thanks. Barbara my question actually had to do with - and you may be addressing this later when you put out your examples. But having to do with captive arrangements because as a TPA we have several captives that come into play.

And typically speaking a captive is really more of a reinsurance type of arrangement. But generally speaking the carrier has to actually issue the paper for fronting arrangements to satisfy state regulations.

So in those particular instances would it be the captive organization that's the RRE or would it be the carrier that's actually fronting the paper?

Barbara Wright: I don't want to get mixed up in terminology such as fronting the paper. If the - if whoever takes out the policy is the insured under the contract the expectation is that they are actually making all the payments. And only if they fail to do so does the fronting policy even have any actual responsibility than the insured - the one that purchased the policy would remain the RRE.

Is that sufficient to answer your question or did I...?

(Jeffrey Haynes): I believe that is. Thank you.

Coordinator: Your next question comes from (Erin Zeger), Smith Moore Leatherwood.

(Erin Zeger): Hi Barbara this is (Erin Zeger). I was just curious - I wanted to clarify - and you answered it some in your examples. But in terms of the amount above the deductible and you said you were looking at in terms of the insurer would always be the RRE.

Barbara Wright: What we were looking at - when we started out the basic rule was for the deductible - the insured would always be the RRE and the insurer would always be the RRE for the amount above the deductible.

And as we've put in the first documents we had out we were looking for ways to cut down the number of duplicate reports without inappropriately assigning any 111 responsibility.

And we said that in situations where the insured - so we went partway there. We said well when the insured is actually making payments to the insurer for the deductible the insurer then pays the injured party we'll make the insurer the RRE for both portions.

The third thing that we're looking at and isn't in writing on any website at this point - is to take that one step further and say any time there is an amount paid above the deductible inherently the deductible has been paid.

So in that situation to have the insurer reports since it would already have a reporting obligation doesn't really give them any burden or any greater risk of a penalty and they would simply report the total of the deductible and the amount above the deductible.

(Erin Zeger): Okay so the insurer would be responsible for everything and that's what you're looking at.

Barbara Wright: Yeah. But again I caution that looking at - we also have questions that want to flip it the other way and say if the insured not only pays out the deductible but pays out all amount above the deductible can we apply the rule in reverse order and make the insured the RRE in all situations?

So we're trying to look at that, you know, across the board.

(Erin Zeger): Okay. But in terms of a worker's comp plan for example and it's fully insured then that - in that case the insured entity doesn't have anything to report if there's not even $1 deductible. Is that correct? It's the insurer that's reporting the entire amount.

Barbara Wright: If there is no deductible - I can't think of a scenario right now that we've heard about that the insured would - I'm sorry - the insurer would not be - let me rephrase it. The insurer would normally be the RRE when there's no deductible.

(Erin Zeger): Okay. Okay thank you.

Coordinator: Your next question (Tom Kennedy), Ace Insurance.

(Tom Kennedy): Hi Barb it's (Tom Kennedy). Just a quick question on defining the term high deductible has - is that going to be defined or we've given up and just said it's anything with a deductible?

Barbara Wright: I don't - if the industry can give us a reason why but in looking at it it seems to me - it seems to me and those of us that have discussed it here that we see no reason why we wouldn't have the same process for high deductible or low deductible.

So, you know, I'm not sure that makes a difference. The issue really seems to be because deductibles are self insurance how do we handle those?

(Tom Kennedy): Okay. Well some deductibles are just very low so I just wonder about the effectiveness of having somebody register as an RRE for such a low...

Barbara Wright: We're wondering too. That's why (unintelligible).

(Tom Kennedy): Okay. And then a quick question - follow-up to that is when you say model form is that the form that we would fill out if we could not obtain the data?

Barbara Wright: I probably should not have called it a model form. It will be model language for our RREs to use. And we are looking for a way that if it's completed that we can give you language that potentially offers you a safe harbor if you have the form completed.

(Tom Kennedy): Okay.

Thanks.

Coordinator: Next question (Bob Russell), Sedgwick CMS.

(Bob Russell): Thanks and good afternoon everyone. I just wanted to clarify again from the TPA perspective that when we have a large deductible program and the insured is giving the carrier the funds for their responsibility for payments that occur within the deductible and then the carrier is depositing funds into the claim paying account is it the carrier or the insured that is the RRE?

Barbara Wright: Under the example we gave today it would be the insurer that is the RRE.

(Bob Russell): The insurer?

E-R or E-D?

Barbara Wright: E-R.

(Bob Russell): Okay thank you very much.

Coordinator: Next question (Tanekia Lewis), (MICA).

(Tanekia Lewis): Hello, thank you. Our question is in reference to billed 101 on Page 111.

And the fourth sentence I guess it says “For annuities base the total amount upon the time (unintelligible) used in calculating the purchase price of the annuity or the minimum payment amount.”

So our question is we're an RRE. But sometime we'll make a $100,000 payment and then we'll purchase an annuity. And then the annuity company actually pays the Medicare beneficiary.

We originally thought the annuity company was the RRE for the annuity. Is that a correct statement?

Barbara Wright: No.

When the insurer settles, has an award, other payment, whatever you want to call it they are coming up with a sum and a settlement. And as part of the settlement if the settlement stipulates the structured settlement, stipulates the annuity and say there'll be an annuity for X amount then in that case the RRE is still the insurer.

But what they need to put down for the TPOC is the calculated amount based on either what the minimum payout of that annuity or structured settlement will be or based on the time period that was used in calculating that structured settlement or annuity - whichever one results in the larger amount.

So the RRE is - the insurer is going to continue to be the RRE there. The fact that the RRE may purchase an annuity doesn't change who has to report it. Similarly if there's a settlement and the injured party simply chooses to purchase an annuity again in that case the RRE would simply be reporting the entire amount they pay.

It's only when the settlement actually calls for or dictates or includes the annuity or structured settlement that you would be taking that into account in calculating your TPOC amount.

(Tanekia Lewis): Okay. And one follow-up question to that. If punitive damages are included in that are we to subtract the punitive damages or no?

Barbara Wright: No because as we've said on other calls we're not bound by the allocation of the parties. It depends. If you've got a jury award and there's a hearing on the merits and stuff then when we get the information - the entire amount you've reported - you can be certain that the beneficiary's attorney or other representative will be telling us and giving us court documents to show what the settlement was actually for.

And if w don't have a recovery claim against a portion such as punitive we will take care of not including that in a recovery claim.

(Tanekia Lewis): Okay thank you very much.

Coordinator: Net question (Robin Pack), Sedgwick.

(Robin Pack): Yes, I'm sorry. I was going to ask how do changes as far as in personnel reflect the identified roles in RRE registration? As far as auth rep and account manager as the RRE are we supposed to get in touch with the EDI manager at that point?

If roles change for authorized rep or account manager?

John Albert: Yes contact your EDI representative.

(Robin Pack): Thank you.

John Albert: They're a couple - I mean a lot of the information can be updated through the portal itself but there's a couple of things that can only be done by EDI rep and that's one of them.

Barbara Wright: I think a lot of these including that question I think are answered in the quick reference guide.

So be sure and pull that down if you haven't already done so.

Operator?

Coordinator: Next question, (Debbie Mitchell), Simmons Cooper Law Firm.

(Debbie Mitchell): Hi. My question is does Medicare know when they're going to draft anything regarding section 111 for the plaintiff's side?

We feel like we have no direction. There's an awful lot out there for the defense but it very much affects us also and we want to stay up on it too.

Barbara Wright: As the plaintiff doesn't have any reporting responsibilities under section 111 I don't think there will be specific 111 instructions for - any obligations that an attorney has or beneficiary has where they need to keep us notified, where they need to repay us - none of those obligations have changed because of section 111.

So if you were self identifying to the coordination of benefits contractor when you're at a pending case that type of activity should continue. Also the only way you're going to get information about at least interim conditional payment amount.

So there isn't any change really for the plaintiff's bar.

(Debbie Mitchell): So when the defense tells you the way I'm understanding that a settlement has been agreed upon in May then in turn you are going to send us a letter stating that that defendant has provided you with that information and...

Barbara Wright: We may or may not. We expect that individuals that have been self reporting will continue to do so. In fact we would expect the self reporting to increase because if you wait - first of all when they report under section 111 they're not reporting until there's been s settlement judgment award and they're certainly not reporting until they've met the criteria for how we defined the TPOC date.

They also only report once a quarter. They also have a 45 day grace window. If something happens within 45 days of their submission date they can defer reporting for a quarter.

So if you rely solely on them that means they you may have been holding on to the money for quite a period of time before we would even start developing a case.

It's in the best interest of any beneficiary's attorney to have the information as soon as possible. You are already technically obligated under the law to repay us within 60 days of any time funds are received or a settlement judgment or award.

(Debbie Mitchell): But in cases like ours which are asbestos cases we may not receive that settlement judgment or award for years. So if we report that to you and we have 60 days to get that paid we don't have that money here and it's going to...

Barbara Wright: We - if you're reporting that type of situation because you want to have conditional payments, et cetera, you also need to let the Medicare secondary payer contractor clearly know that the settlement has not been funded yet.

(Debbie Mitchell): Okay.

Barbara Wright: And let them know when it is funded. Because you - and if they happen to miss that and go ahead and send you a demand letter you need to reply immediately that the settlement has not been funded yet and that you will notify them when it has been funded.

(Debbie Mitchell): Okay. So with us both reporting this isn't going to cause problems in the system and it's not going to be two different cases. Is that correct?

Barbara Wright: We are setting up procedures on the backend so that our Medicare secondary payer recovery contractor will determine which reports are duplicates.

(Debbie Mitchell): Great.

Barbara Wright: Okay?

(Debbie Mitchell): Okay thank you.

Coordinator: Next question, (Jim Price), (Aeon) Global Risk Counseling.

(Jim Price): Yeah this is (Jim Price). I'm not from Sedgwick.

Anyway I - first of all I really do appreciate Barbara you and your team. You really have done a great job in fielding these questions and really do appreciate all of your efforts.

I have a couple of questions.

One has to do with clinical trials. We do have some clients where there is no actual settlement that is reached with a patient who may be receiving medical benefits because of complications involving medical trial and there is no, you know, there's no request for release.

However there are payments being made to that person or the complications of their medical condition arising out of the clinical trial. How does that get reported or should it be reported?

Barbara Wright: As I said we're - right now we're working on language for clinical trials and that's one of the issues is exactly how we would have you report it and when you report it. Because clinical trial sponsors often take that responsibility from day one even though they may not be paying anything until an actual injury or complication arises.

So that is what we're looking at in trying to draft language.

(Jim Price): Okay. Any idea what your timeframe here is on that?

Barbara Wright: Our timeframe for most of this is as soon as possible. But the first thing we're working on right now is trying to get the example of the RREs out.

(Jim Price): Okay, understood then and appreciated.

The other question that I have is we have some carriers who are trying to make a distinction regarding what is a deductible and what is an SIR payment. For example we have one carrier who was actually funding the settlements - billing our client back but because they consider the client to be an SIR they're considering the client to be the RRE.

And I think this is a semantic issue and I'm just wondering how do you guys look at this?

Barbara Wright: We will try and address it in examples.

What I hear you telling me is that you have a situation where the insurer actually has the excess insurance or the amount above the self insured retention amount, is billing the insured for the self insured retention amount, is paying that amount out on behalf of the insured. But is still stating that they believe the insured is the RRE for that SIR, correct?

(Jim Price): That's correct.

Barbara Wright: Okay. We'll put that in the examples.

But I think we're - I would expect that to end up as the same as the deductible because we're talking about - although a lot of the discussions has been cast around the word deductible what we were talking about is essentially the self insured portion when it's paid out through an insurer that the insurer would typically be the RRE.

(Jim Price): That certainly is our understanding and I do appreciate your clarification. Thank you.

Barbara Wright: When we put examples on the website if you see places where terminology needs to be added to like if we focus on deductible then an appropriate comment would be would the same example apply if instead of a deductible it was an SIR for this portion? That will help us clarify language if we miss it.

(Jim Price): Yeah I know we're all trying to speak the same language. Do appreciate those comments; thank you very much.

Barbara Wright: Thank you.

Coordinator: Next question, (Ryan Asmuth), Illinois Hospital Association.

(Ryan Asmuth): Yes hi, good afternoon.

My question primarily concerns the internal hospital write-off of charges. That to me seems to be probably one of the largest landmines out there. And I think in past calls you've defined other payments to include internal hospital write-offs. Am I correct?

Barbara Wright: Yes we have and actually we're having some internal discussions about this. We may have even had your question because I remember the word "landmine."

(Ryan Asmuth): Okay.

Barbara Wright: But we don't have any final wording on that yet.

(Ryan Asmuth): Okay - yeah and anything you can do to really help clarify that. Because that to me is from a process point of view something that I know a lot of hospitals do internally and then they don't report it either to an insurer or to a TPA.

And so anything you can do to clarify that would be great

Barbara Wright: Yeah I mean we're also hearing the examples range from situations where the hospital is writing stuff off because they have an actual claim. They're writing it off in a proactive effort to get someone to not have a claim. They're writing it off - I'm sorry - they're telling the beneficiary that they won't charge them but then they're going ahead and billing Medicare so they're really if anything writing off deductible which is a whole - as you can imagine is a slightly different issue.

(Ryan Asmuth): Yeah, definitely there's compliance issue there. I guess one example I would throw out there would be that let's say a patient in the middle of the night falls out of bed or climbs over the rails and complains of hip pain. And so the hospital takes an X-ray or a CT to confirm no injury and in fact there is no injury but there's a - technically a $1,000 itemized charge on that patient's account.

At the end of the day that provider will likely bill Medicare for a DRG amount. And that $1,000 incurred charge really doesn't get billed to Medicare because they're just going to get reimbursed for the DRG that the patient was in for since the fall didn't change the patient's condition or add really any additional medical care.

So the $1,000 charge actually on the bill to Medicare would actually be an itemized charge with no amount attached to it. And would something like that be considered a write-off?

Barbara Wright: I guess we may need to talk to other areas here because although it may not change the DRG I don't have enough knowledge to know whether the

additional charges like that would automatically in essence not be billed to as per se but end up paid by us in the context of how the cost reports are settled.

(Ryan Asmuth): Right, exactly.

So, you know, and anything you can do on the internal hospital write-offs would be greatly appreciated.

Barbara Wright: Okay.

(Ryan Asmuth): Thank you.

Coordinator: Next question, (Donna Buchard), Farm Bureau Insurance of Michigan.

(Donna Buchard): Hi there. I have a question about ORM. We're having a difficult time interpreting what the meaning of assuming ORM is internally for us. We have auto accidents that come in and everybody that we know is - was in the vehicle we open claims for them but then in the course of the investigation we find that there's no ongoing responsibility for medical so we have not issued a payment.

I've also heard that you don't want us to report anything until there's a judgment settlement or award and I wondered if that's strictly related to TPOC or can be used with ORM as well.

Barbara Wright: Three or four part question there.

(Donna Buchard): I'm trying to squeeze them in out of Sedgwick.

Barbara Wright: What we've said for ORM was we would like it reported as soon as it's assumed - as soon as you've decided that you are going to be paying claims. We've said that in a situation where you're paying a medical bill as part of the investigation like a medical exam that you're paying for we don't consider that part of ORM, we don't consider it a TPOC, you don't have to report it.

Otherwise when you've opened it and expect to pay bills that come in you should report it even if you haven't yet paid one. Because our purpose in ORM is to stop erroneous payments here so that we don't have to come back to the insurer or the worker's comp entity and say, "Hey you told us about an open no fault record and we've been paying on it because we didn't know you had this open record."

That's the value to you in letting us know about it as soon as possible. Don't try and separate the ideas of TPOC or ORM and associate one to settlement and one to something else. The statutory language is settlement judgment payment, or - settlement judgment award or other payment so that we would cover all situations including the ORM type situation.

TPOC does not automatically mean a settlement. You could have - and many insurers have told us they routinely dispose of cases with a check because they believe it will be satisfactory and there is never any formal settlement signed. But that would nonetheless be a TPOC situation.

Does that help some?

(Donna Buchard): I'd like to reiterate or to say back what I think you said.

Barbara Wright: Okay.

(Donna Buchard): So we need to report ORM as soon as we know that we are going to pay bills, not based on the fact that we pay our first bill.

Barbara Wright: Right. The one exception to this - and we know we need to do some tweaking with it to - is ORM not for no fault and not for liability but ORM for worker's compensation. We are - we do have a published threshold for reporting that that we're looking at raising.

For worker's comp ORM situations that are medical only claims that are below a certain threshold and involve a limited or no lost time days, et cetera, and all payments are being made to the vendor because they fit that whole category then we are exempting them from reporting.

So you need to take a look at that alert. We would expect that situation to occur most often. Let's say someone sprains their wrist and goes to the emergency room or they think they might have broken it - they go to the emergency room, there's x-rays, they get the sprain taken care of. And basically there's no more treatment expected.

It's pretty much tied up and you can tell right away that it should fall under those criteria. Some of the ones where you know someone's in a car wreck and it's not just going to be that then yeah as soon as you know that you're going to be paying bills you should be reporting the ORM.

(Donna Buchard): Okay. Unfortunate for us but - because I don't know how we're going to know that but - anyway so you don't need to know that.

But then my - I'm just going to ask one follow-up question. As far as reopening ORM I'm not sure what you u mean - you said it's whenever something else comes in on that claim...

Barbara Wright: Well essentially it's when you're required to pay more on the claim. If you have a situation where someone has under state law lifetime medical...

(Donna Buchard): That's us.

Barbara Wright: Okay.

When someone's applying for additional benefits you should be reporting that. Because they've essentially sort of activated your record for you again.

(Donna Buchard): So if we get correspondence and we investigate, we find this is not as a result of the accident we do not have to report that to you.

Barbara Wright: Let us think about that a little bit more because if someone is saying that their injury is reactivated arguably the ORM should be open in case the one service may not be but they may have a second service.

So...

(Donna Buchard): I can tell you that most often we receive these that are not related to the accident because they're just trying to get us to pay lifetime medical for all medical.

Barbara Wright: Okay can you - do you mind doing a separate note to the mailbox and just reiterating the point you just made?

(Donna Buchard): Not at all.

Thank you for your time.

Coordinator: Next question, (Laurie Busharm), Compass.

(Laurie Busharm): Hi. I have a question or looking for clarification on the worker's compensation deductibles. Worker's compensation is unique in that the insurer is still required to pay first dollar but they need to be reimbursed by the insured.

And in fact the endorsement that we attach - the standard endorsement for deductibles talks about that this endorsement doesn't change the insurer's obligation under the work comp law. However we're entitled to reimbursement from the insured.

I think what confuses the issue is where there's a TPA involved. Rather than insurer pay everything and get reimbursed by the insured the TPA will go to the insured for funding within the deductible layer and then to the insurer for that in excess.

Barbara Wright: Let me ask you in that context who has the contract with TPA? The insurer?

(Laurie Busharm): Many times the insured will and that's because they want to keep their third party administrator consistent as they may change insurance carriers. And so I have some difficulty when I hear it being put in the realm of self insurance because technically as the insurer we are obligated the first dollar to be reimbursed by the insured.

And I think the funding, you know, looking at where it's being funded determining who to report I think is confusing the issue.

Also the insurer does need to have that first dollar data available and that's because in many states there's loss based assessments that cause us to pay on first dollar. So the insurer should have data for both layers within their reporting system because of their financial reporting responsibility.

It actually comes through as a payment and a reimbursement even if the TPA paid and sought reimbursement from the insured for the deductible layer and then from the insurer for the excess. And it is unique to worker's compensation.

Barbara Wright: Can I ask you to do a note that the subject line is really first dollar and this issue for worker's comp?

(Laurie Busharm): I will. I actually did send something in but I'll expand on it with wording off of the deductible endorsement. And you want the subject line to be first dollar worker's compensation?

Barbara Wright: Yeah and if you don't mind giving your telephone number...

(Laurie Busharm): Oh sure I will.

Barbara Wright: In fact we're not saying we use it but any of you that send in the complicated questions if you want to give us your contact information that means if we need to expand on it a little we can call you as opposed to always having to write you. So that would be helpful just for future reference.

And what you said on this it's not that I disagree with anything that you said. But we're going to have to be able to distinguish if possible how this is different from a deductible type policy that's not worker's comp where they under their contract are ultimately responsible but yet the - I'm sorry - they're

ultimately responsible under their contract but yet the deductible is paid out by the insured.

So...

(Laurie Busharm): Right. And for us at least for the non-worker's comp we don't pay the deductible layer - the insured pays that directly. And in fact if you came to us with a burden to report we would have an issue because we don't have that data.

We only have ones that pierces that deductible or we only have data at that point.

Barbara Wright: Right.

(Laurie Busharm): So...

Barbara Wright: But the augment or statements of a lot of the industry for non-worker's comp is the flip side of yours. They're presenting language that's very close if not the same to what you're saying about your first dollar responsibility.

(Laurie Busharm): Okay that would surprise me on the other lines but I will send what I have on worker's compensation.

Barbara Wright: Okay. Thank you.

(Laurie Busharm): Thank you.

Coordinator: Next question (Yvette Lynch), Brown and Brown Insurance.

(Yvette Lynch): Hi. Our question is one on the fines. I know in the past it's been iterated that, you know, that wasn't the main objective and nothing was clearly defined.

But in light of the extensions what is your expectation as far as levying of fines at this point?

John Albert: I mean right now I mean we do not have any guidance, you know, published related to that. We really can't comment to that. Basically I will say as I've said on many of these calls that, you know, the best way to put yourself at risk - or keep yourself at risk of non-compliance is to essentially register test and submit data based on the timeframes we have published out there.

Barbara Wright: I think you meant to eliminate the risk of non-compliance.

John Albert: Sorry if I said it backwards.

(Yvette Lynch): That's okay. Thank you very much.

Coordinator: Next question does come for (John Spellman), Nationwide.

(John Spellman): Thank you.

My question is about the material on Page 58 of the user guide regarding data incident and exposure claims related to the December 5, 1980 date. And as an example given where three defendants in an asbestos case the exposure for one of them is - or ends prior to December 5, 1980 and no report is required.

My question is that it appears that "exposure" as the term is used there and it's used in quotes refers to actual exposure. That is the period during which the

claimant ingested the substance that is the basis of their claim - in this case asbestos.

As opposed to the idea that they've ingested something and it stays with them for the next 20 years and they're exposed as it remains in their body. But as I read the example here it appears to me that we're talking about actual exposure.

Barbara Wright: Well we actually have yet another variation on that from a conference we were at last Friday. What you're talking about exposure to the substance in most situations where we're talking about like it's airborne or something like that when that exposure from an outside source ceases we consider the exposure to have ceased.

One situation - very large situation we had in the past where some people might view our position on exposure as a little bit different was with gel implants. If someone had an implant prior to 12-5-80 and it was removed prior to 12-5-80 and there had been no rupture we considered that the exposure ended before 12-5-80.

But if the implant had actually ruptured so that the whole mass of the substance that was considered to be allegedly toxic or creating the problem clearly remained in the body then we considered the exposure to continue.

But for the example you gave where there's pollution or...

(John Spellman): Asbestos.

Barbara Wright: Or asbestos when they're no longer being exposed to that yes we've considered the exposure stopped.

(John Spellman): When they're no longer exposed to it from the outside.

Barbara Wright: Right. Like for instance if they were working in a brake shop let's say so they were exposed to asbestos and they quit and from then on they worked at a swimming pool...

(John Spellman): Right.

Barbara Wright: We're not worried about exposure.

The other thing that we need to look more closely at the language on is we got into a discussion where we ended up somewhat circular what was being discussed was exposure - or at least my memory of the conversation was that some of us were talking about exposure in terms of legal exposure.

In other words if the physical exposure continued that entity X started but the company was bought or sold by someone else were we dividing up the legal exposure of entity versus the physical exposure.

So we know we're going to have to take a look at this language and tighten it up.

(John Spellman): Okay. But as I understand it then if a person was working at a job site, there's asbestos insulation there, they breathe it in in 1975 and they're never in contact with asbestos again that exposure ended in 1975.

Barbara Wright: Right.

(John Spellman): Okay that's what I wanted to know. Thank you very much.

Coordinator: Your next question comes from (Norman Reese), Louisiana Insurance Guaranty Association.

(Norman Reese): Okay in a previous phone call you stated that if we paid attorney fees direct to the attorney you would not include that in the TPOC. Today you said attorney fees would be included in the TPOC.

Could you clarify that?

Barbara Wright: There's two different things. And if we need to clarify what we said before - what we're talking about there are some situations - and we've heard it most often associated with worker's comp. In most liability insurance type situations what we routinely encounter is entity X is settling with John Doe for $100,000.

And John Doe is expected to pay his attorney out to that. In that case you definitely are not subtracting any information about attorney fees.

(Norman Reese): Correct.

Barbara Wright: Regardless of whether you cut two separate checks. So that settlement was for $100,000 and it's expected to cover all attorney fees whether you cut one check to the attorney and one to the claimant you still report the TPOC amount of $100,000.

Now if you have a separate settlement situation where you say, "I'm settling with you John Doe for $100,000 and I will pay your attorney fees whatever they are above and beyond that $100,000" then the only amount you would

report as the TPOC is the $100,000. And whatever you paid the attorney wouldn't be reported.

(Norman Reese): Well that'd be mostly in worker's comp cases where you pay (unintelligible) direct.

Barbara Wright: That's our understanding.

What the reg - we have a regulation that when we're doing a recovery claim that we do a pro rata reduction of our conditional payments. There's some special rules about caps and everything. But we do a pro rata reduction of our conditional payment amount to take into account attorney's fees and costs that are actually borne by the beneficiary.

So if the beneficiary gets a $90,000 settlement and worker's comp is in a state where it just goes straight - all of it goes to the attorney - to the claimant and he's responsible for his attorney fees then we would do that reduction.

But if it's in a situation where the state routinely pays attorney fees of X% and they're always paid above and beyond the award or the settlement in that case for the TPOC all we would want is the actual award and settlement - not the attorney fees as well.

In that case you're not really deducting attorney fees from the TPOC amount. You're just not adding them because they're not part of your settlement with that person.

(Norman Reese): Okay.

Coordinator: Next question, (Bill Thompson), The Hartford.

(Bill Thompson): Hi. My question I think is similar to one that was previously asked about captives and context of fronting. And mine doesn't have to do with captives. So the issue would be a traditional insurer uses another company's paper in a particular state and the insurer pays all the claims itself.

My understanding in that case would be that the insurer that's handling the claims, that's paying the claims would be the RRE and not the company on whose paper it is written.

Barbara Wright: Again I may be hearing some of the terms wrong but just in the phrasing of whose holding paper. If I can rephrase what you said you have entity X who needs to have funding insurance because of state law. Entity X purchases that fronting policy but the fronting policy never pays anything. The purchaser is paying all the claim. That's a fair statement?

(Bill Thompson): That's right.

Barbara Wright: Okay in that case the purchaser who we would consider the insured yes is in fact the RRE.

(Bill Thompson): Well okay the purchaser's really not an insured. It's really a case of one insurance company is using another insurance company's paper because of some advantageous rules in that particular state.

Barbara Wright: What we're trying to say from concept was the paper that was purchased - the fronting policy - there is never any intent that it will actually ever pay claims and it never in fact pays claims, correct?

(Bill Thompson): That's right.

Barbara Wright: Okay so it is not the RRE.

(Bill Thompson): Right.

Barbara Wright: Does it help if I phrase it that way?

(Bill Thompson): Thank you. That confirms my understanding.

Thank you.

Coordinator: Next question comes from (April Johnson), Data Health Care.

(April Johnson): Hi Barb this is (April Johnson) from Data and I've been communicating with you about the joint powers authority issue. And I wanted to follow-up with you on my question regarding Page 19 of the user guide - specifically the section regarding the RRE for liability self insurance pools and whether CMS has reexamined number three.

And that specifically pertains to the phrase "without involvement of the participating entity."

Barbara Wright: And I believe your issue was a situation where the employer had to essentially approve the settlement, correct?

(April Johnson): As the - excuse me - the member of their risk sharing pool would have the consent, yes.

Barbara Wright: Would have to give consent.

(April Johnson): That is correct.

We would not be able to settle the case without their written consent because in California we have requirements for reporting to the medical board and data bank. So we do have to get the consent in many cases.

Barbara Wright: We're continuing to look at this but we don't see any way that that would allow where you have to get the member's consent that in that situation the member would be the responsible reporting entity.

(April Johnson): I'm sorry say that again.

I didn't...

Barbara Wright: You have to get the member's consent. The member would be the responsible reporting entity.

(April Johnson): Okay. So as I've indicated before for many joint power authorities they have as part of their agreements with the members that they will obtain their consent especially if they do have the deductible as part of that.

And so if the goal of CMS is to reduce the amount of entities that have to register in the port then that's just increasing the number.

Barbara Wright: Right.

We realize that and where we can do it without potentially imposing the fine which we hope to never impose - I mean part of what's driving this is who - the RRE is the one that is ultimately responsible if and when we have to ever impose one of these penalties.

And as much as I personally would like to say here's the rule that applies to the whole world and this will be the one portal we can't do that if we view it as a situation where if that entity would fail to report that they don't meet the definition of who would be a responsible entity under the statute where we're talking about the applicable plan as that's defined in the statute.

So we're struggling with this as much as you are. But we're trying to remain consistent to that requirement. And, you know, if we can come up with some way to get around some of this fine but in the long run we may - there's going to be certain areas where we're just stuck.

(April Johnson): I guess what I'm not understanding is if the goal is to get the report why would it matter whether it's the member that has the consent ability versus the pool itself that is managing...?

Barbara Wright: A goal is to get the report but we also have to have a structure that potentially allows us to impose penalties on an appropriate entity. If we said okay the pool is the responsible reporting entity but under the statute they aren't then if there's a failure in reporting who's responsible for that penalty?

We can only say someone is the RRE if we believe through a consistent reading of the statute that's ultimately who could be held responsible for the penalty.

(April Johnson): So at this point in time you don't anticipate that this provision of the user guide will be changed.

Barbara Wright: At this point, no.

(April Johnson): Okay. Thank you.

Coordinator: Next question comes from (Willie Wrestler), Trinity Hospital.

(Willie Wrestler): Thank you. I have a couple of questions. In regards to the $5,000 say for example we have five patients in (unintelligible) or secondary payer we're writing it off versus for charity care, bad debt, and just PR issues and our total out of those five claims equals over $5,000.

Do we report that or is it by claim?

Barbara Wright: The threshold applies per individual beneficiary.

(Willie Wrestler): Okay.

So that in case we wouldn't be reporting any.

John Albert: Yes under that scenario yes, that's correct.

(Willie Wrestler): Okay. Next question - this only pertains to Medicare secondary pay then, right? Or Medicare secondary?

Barbara Wright: Section 111 reporting is only for Medicare secondary payer situations.

(Willie Wrestler): Okay next question.

Say I'm a young person working and I'm exposed to asbestos. And it never shows up till I'm on Medicare three or four years down the road on Medicare. Then what happens?

Barbara Wright: I'm not sure what you mean.

If you have a worker's compensation claim and you're a Medicare beneficiary we have always been secondary to worker's compensation and we need to know about that situation. That's why we have the monitoring provision if the ORM is open.

And if the ORM is technically closed under your state law, et cetera, then we'd have to look at the specific case. If it's being pursued as a liability insurance issue if there is a claim and there's ultimately a settlement judgment or award or other payment then we're secondary.

It's not driven only where the exposure ends before 12-5-80 and it is a liability insurance claim do we get into any concern about what the date of exposure was. If it's worker's compensation we don't care when you were exposed. If worker's compensation has responsibility we're secondary.

(Willie Wrestler): Okay thank you.

Barbara Wright: Okay.

Coordinator: Next question (Noel Godding), (Olan).

(Noel Godding): I have an RRE question. We sold a portion of our company and the hold company assumed responsibly for handling and paying the prior claims by contract with us.

And they paid for those claims from their checking account. But as part of the sale we gave them a lot of cash to fund those claims. So ultimately they're

using our money to pay the claims but they're handling and paying the individual claim.

Barbara Wright: I need you to send that in in a note.

(Noel Godding): Okay. And where would I send that?

Barbara Wright: If you go - you know what our website is?

(Noel Godding): Yes.

Barbara Wright: If you go to that website go on the overview tab and one of the downloadable documents is an opportunity for public comment. When you go in that document it not only gives you some tips about sending comments but it gives you the mailbox that you need to send it to.

(Noel Godding): All right. And I had another question. I heard - I came on the call late but I heard that you're not to report a liability claim until there's a judgment settlement or award.

Is there any timeline if you - once the claim comes in if you have the information can you query the claimant and then wait a couple of years until the claim settles to actually report it?

Barbara Wright: First of all it's not just for liability. It's for liability insurance including self insurance, no fault insurance, and worker's compensation. All three of those we do not require reporting. We do not want reporting until there is a settlement judgment award or other payment.

And other payment includes assumptions of ORM. If you get a claim filed with you in 2007 and you aren't paying any medical and it's - let's say it's intensely litigated because it's for a gazillion dollars and it doesn't settle for rent years. We don't want to know about it until ten years down the road.

You can do an initial query if you'd like to but you certainly need to know for sure about beneficiary status as of the date of settlement judgment award or other payment including as of the date you would assume ORM.

(Noel Godding): So there's no - because I heard there was a 90 day timeline after your query that you have to report a claim.

Barbara Wright: That's not tied to when you report. What we said is there - reporting is done once a quarter. So it's done approximately once every 90 days. And we also have timeframes connected with how often you can query.

But the bottom line rule is that you don't report until there's been a settlement judgment or award or other payment including the assumption of ORM.

And if it's liability and the case drags on for years then you're not going to be reporting until you've got an end result. And if the end result is in the defendant's favor then you're not going to be reporting at all.

John Albert: The timeline factor kicks in when there is a settlement judgment or award.

(Noel Godding): But there's no problem with doing an initial query.

John Albert: No.

(Noel Godding): Okie doke. Thank you very much.

John Albert: No but for that questioner when the initial query in 2008 and then (unintelligible) or then seeing the you've got a settlement judgment or award or other payment 2012 and relying on the 2008 query is probably not a good idea.

Barbara Wright: Well you basically can't. You need to know beneficiary status as of when you have a settlement judgment award. So it's fine if you do an initial query. But you can't rely on that as the end all and be all.

Operator?

Coordinator: Next question does come for (Linda Briniack), LWCC.

(Linda Briniack): Hi. My question is twofold and it's returning to the fronting situation.

And it concerns me greatly that we're going through some examples and depending upon how the facts are presented it looks like it could go either way and it concerns me that we're using broad strokes to make decisions on what could end up being many, many different scenarios that are greatly fact driven.

Stating that the definition of insurer in the user guide specifically says that in return for the receipt of a premium assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments.

And that insurer has the responsibility for the reporting requirement. So in some fronting situations company A is receiving the premium and issuing a worker's compensation policy. There may be another contract behind the

scenes between company A and company B to shift the liability to the company B as an excess carrier.

However company A is writing the policy and issuing the policies to those employers. How can they not be the RRE?

Barbara Wright: We'll take your comments into consideration but you also have to factor in although the industry doesn't like it that we do have a statutory definition of self insurance. And that's what butts up against the other definition.

And where the self insured is actually doing the paying, et cetera, then we've made them the RRE.

(Linda Briniack): But this is a fully insured situation from dollar one. So I'm a little confused as to how the - a self insured situation would overlap across this.

Barbara Wright: I thought you said it was a situation that involves fronting where presumably the entity that purchased the fronting policy - the intent expectation has actual performance is that they will in fact pay all the claims themselves.

(Linda Briniack): But that's not at all a self insured situation. I mean a policy's written to cover the claims from dollar one.

Barbara Wright: I - we will take your comments under consideration. We understand that the industry does not agree with our definition of self insurance. But we have a statutory definition that we're working with.

(Linda Briniack): Okay and then secondarily and you may just be able to give me some guidance on this. If there is a dispute regarding which carrier is the RRE what is the formal mechanism to resolve that?

Barbara Wright: At this point we don't expect to have a formal mechanism. We want to make the examples clear enough - and I think certainly the discussion we just - the example we just discussed we will have clear language on this.

That will be our policy in terms of who is the RRE.

(Linda Briniack): Okay. And if you provide that clear language then that will help us greatly. It's just so difficult to imagine that you're going to provide examples for the many, many different scenarios. But I'm certain that that will help us.

Barbara Wright: Well I mean that's why we're going to be asking you as participants in this to tell us what additional concepts or language we need to add to any examples to make sure it covers what you want.

We've said over and over again that there's no way given the multitude of situations that are in your industry that we can provide an example for every single situation that's out there.

(Linda Briniack): Okay if we mailed it in yesterday is that sufficient or you need us to put it back in the queue?

Barbara Wright: If you mailed something in yesterday we'll see it. But I guess what I'm saying is at this point we expect to put the examples out as a draft and we'll be asking for specific comments on those specific examples.

(Linda Briniack): Okay thank you.

Barbara Wright: Thank you.

Coordinator: Next question (Veronica Merritt), Smith (Hoye).

(Veronica Merritt): Good afternoon. My question relates back I think to a couple the earlier questions and I'll look forward to your future guidance on this whole issue of write-offs.

But I guess I'm going to ask if you would maybe assume - first of all I represent health care providers. Assume that all of the providers I'm talking about are all insured with a commercial insurer for purposes of malpractice coverage that they may or may not have deductibles under those policies.

But what will occasionally happen is that a Medicare beneficiary who will have received treatment will have a complaint.

There - the Medicare beneficiary will not retain legal counsel, will not come in making a demand for anything per se but will have a complaint. And occasionally a provider will attempt to resolve the complaint with the Medicare beneficiary by maybe, you know, I've got some clients who will give an example of giving, you know, a gift certificate for the hospital cafeteria.

Or they might write-off a amount of outstanding patient bill in their physician office. It may be $100, it maybe $200, something like that. It can vary widely and although most of them will stay under your current threshold designation not 100% of these will.

But in no instances are these individual beneficiaries represented by counsel and in none of these instances does the health care provider get relief legally from any future claim related to the care.

You know, the complaint may be, “Well my scar is worse than you said it would be.” Or it may be, “My dentures were chipped during intubation.” I mean these are not legal - these are not medical malpractice complaints per se and the provider may not believe they have any liability whatsoever.

But of all of the conferences that I’ve listened to I am concerned that my clients in these contexts may be RREs or that you may expect that they are RREs. And the imbalance of the understandable burden that is associated with being an RRE - I understand why there’s so much involved in doing it.

But for something that may happen once in a 12 month period over the threshold for a hospital to have to be - or for a small physician group to have to be an RRE seems imbalanced.

And I’m wondering am I - are we not understanding something or are you still working to clarify this?

Barbara Wright: We understand your concerns and we understand how in some situations, you know, it might even be an issue of property damage or something else. If someone said they didn’t like the food is entirely different than you dropped me out of bed.

(Veronica Merritt): Agreed.

But I’m not talking about a “you dropped me out of bed.” I’m talking about you said I would only be off of, you know, I would only have two days of recovery and I haven’t been able to get out of bed for a week. Or you told me that my scar would only be an inch long and it’s three inches long and it’s red.

I mean there's no liability here but you have somebody who's unhappy and you don't want them to be unhappy.

Barbara Wright: We understand your concern and that's one of the reasons we haven't written a specific answer on this. We're trying to consider the issue fully before we put anything in writing. But I can't give you absolution at this point that there won't be situations where someone is an RRE.

In terms of the inconvenience whether or not it's what you want to do first of all we said that no one has to register until they have a reasonable expectation. Secondly you potentially have the option as opposed to getting up a whole IT process if you only have one or two.

Some agents might be prepared at this point to be able to do some type of single data input even though CMS is not. And in CMS's long range plans we are looking at whether or not in the future we could have some direct entry for small individual situations like you're talking about.

(Veronica Merritt): So I guess I would just say that I very much appreciate the fact that you're still thinking about it and on behalf of a whole host of health care providers please keep thinking about it.

And I would ask that in the context of thinking about this issue that you also think about the definition of self insured as it relates to the deductible. Because I've read the definition of a self insured plan in the regulations and I understand that you are bound by that in this context.

And I even understand what you're - I think I understand what you're trying to capture by saying that the insured hospital in my case is self insured for purposes of the deductible.

I guess the two comments I would make is one, for the insured hospital, you know, that has a deductible of $50,000 there's no way that that money isn't all getting spent on cost of litigation and attorney's fees 999,000 times out of a million.

There's very rarely ever going to be an instance where that insured hospital deductible is going to pay the traditional medical malpractice claim or the hospital - where the plaintiff is represented by legal counsel and there is a formal claim made to the insurer.

But I would also ask you to think about in the context of a self insured hospital they have - a self insured hospital has a formal plan, an insurance plan that is its own.

They also will find themselves in these instances where they will make a nuisance payment for lack of a better characterization where the money doesn't come out of this pan and it doesn't get factored in by the actuaries who evaluate their plan.

And I would ask as you're thinking about this to also think about that definition of self insured plans because it has implications for self insured hospitals as well and I appreciate very much your time. Thank you.

Barbara Wright: Thank you. Operator?

Coordinator: Next question (Anne Marie Peterson), All State Insurance.

(Anne Marie Peterson): Good afternoon. I know you provided some clarification in your opening comments on structured settlements in an answer to a subsequent question. But if I could just ask one more for clarity.

The field that's labeled "funding delayed beyond TPOC's start date" is the intent that the date that would be neared there would be the date the claimant received the first payment of the structured settlement?

Barbara Wright: No. Oh okay. I'm sorry. I was not listening right to your question.

If you've got a situation where the only cash that's being paid out is by virtue of the structured settlement and the structured - and it was the settlement that dictated the structured payout - it wasn't that the injured party went out and purchased that once they got the cash from you.

(Anne Marie Peterson): Correct.

Barbara Wright: Then yes if they're not going to get the first payout for six months or something yes that's the approximate date we'd want. Part of what we're - as I think I said we're trying to head off that we're not automatically issuing a demand right away when it's clear that it hasn't been funded yet.

(Anne Marie Peterson): Okay. So is the - does that field also default to the TPOC date that you would normally pass on a lump sum payment or is that field not entered in that situation? Or does the TPOC date become the same date that you're filling in that...

Barbara Wright: Do you remember what field number that is or what page it's on?

(Anne Marie Peterson): It's Field number 100 on Page 110.

Barbara Wright: The technical people are going to have to help me out with whether it defaults or not.

She's talking about the funding delayed question. It's 102 on Page 112.

It says fill with zeros if not applicable. So if it is in fact being delayed you give us a date and if it's not being delayed you just give us zeros.

(Anne Marie Peterson): Right but if you're giving a delayed start date as being the first date is then the TPOC date Field number 100 blank?

Barbara Wright: No, no, no.

Your TPOC date should still be the TPOC date as we defined it. This is solely for funding it.

(Anne Marie Peterson): Okay so Field 100 would be the date that I issue the check to purchase the annuity?

Barbara Wright: Okay.

(Anne Marie Peterson): So if today I issue a check...

Barbara Wright: Well that's not the date - it depends on which one of these criteria you met. It's when the payment obligation was established.

So if the obligation is signed and there's a written agreement unless court approval is required it would be with that even if you waited two weeks to issue the check.

If the only time you're really using the check date is when there's been no written agreement.

(Anne Marie Peterson): Okay so again assuming we have an agreement for a structured settlement but the claimant is not getting any payment yet but I am purchasing the annuity now so I use...

Barbara Wright: You would use the date the payment was - obligation was established based on your written agreement as we discuss it in the description of that Field 100.

(Anne Marie Peterson): Okay.

Barbara Wright: And then you would - whatever's going to be the first - expected first date of the structured settlement would be when you'd put in for the funding delayed.

(Anne Marie Peterson): Okay. So there should basically always be a TPOC date associated with every liability record.

John Albert: Yes.

(Anne Marie Peterson): Okay thank you.

Barbara Wright: Unless you happen to have ongoing responsibility for medical which is rare apparently with liability.

(Anne Marie Peterson): Correct. Okay thank you.

Coordinator: Next question (Laurie Pilaster), (Unintelligible) Corporation.

(Laurie Pilaster): Hello.

This question is regarding the - determining whether or not an individual is a Medicare beneficiary. We have a couple of situations that we run into. The first is we don't have a social security number.

The second one we have - and you addressed it earlier in your conference which is we don't have a mechanism to verify that the number they gave us actually belongs to the individual. So they could give us a number that belongs to someone else or maybe doesn't even exist and it would have a name that doesn't match that number.

So going back to how do we - what is our obligation for verifying that information if we don't have a mechanism to know that it's incorrect? So we submit a query to you and we get a result saying that they're not a Medicare beneficiary. It may be that the social security number isn't or it may be there's just not enough matching information.

So how do we get the correct information?

John Albert: I mean we can't necessarily tell you how to get that correct information. You're absolutely correct that the query file in terms of verifying Medicare entitlement is only as good as the information on it.

So even if the SSN is correct, you know, if you don't have enough of the other matching criteria which is the name, date of birth, and gender, that could also result in a no match as well.

We are in the process of developing model language that you can use to solicit that information from that potential beneficiary that would also, you know,

depending on how - I don't know how to say this the right way - but essentially would allow you kind of a safe harbor in terms of demonstrating your attempt to get that correct information.

The things to ask for when doing any type of development on your end is that you definitely want the name as it appears on the social security or Medicare card. That format will ensure that in many cases you may only get a social security number and the name.

It's very important to try to get the name as it appears and the date of birth as it appears on the social security card to ensure that we can validate that yes that person is a beneficiary.

But again you're absolutely correct in that if the information you get is not accurate then we can't validate that it is in fact a Medicare beneficiary.

(Laurie Pilaster): So then what is our liability then if we don't have correct information?

Barbara Wright: I mean this goes back to what we've talked about before. That's why we're working on model language and as John said when we have that out it's a little bit hard to talk about in the abstract. When we have that out I think it will at least lessen if not relieve a lot of people's concerns.

John Albert: Yeah we want to provide a process that if followed will demonstrate to CMS that the responsible reporting entity basically made a good attempt to get the information.

Obviously if someone doesn't cooperate with you, especially in the case of like a liability situation that's something else. I mean the beneficiary is obligated to, you know, cooperate in terms of coordinating their benefits with

Medicare and we're attempting to reach out to beneficiaries and others to basically let them know that this collection effort is under way and why you want to provide that information, et cetera.

So...

Barbara Wright: That's not to say that at this point we contemplate any broad spectrum of good faith efforts that we're going to try and make judgments on. What we're saying is we're trying to create a form - not a form - we aren't doing a form. We're doing model language.

But we're trying to create model language that if what we distribute and make available for you to use that if what's in there is followed it would create a safe harbor in that specific situation.

I don't want to mislead and imply that we're setting up just some general standard of good faith efforts.

(Laurie Pilaster): Okay thank you very much.

Barbara Wright: Operator can you give us an idea of how many people are in queue? Because we do really need to wind up a couple of minutes before three.

Coordinator: You have about 34.

Barbara Wright: Sorry.

We thought with having had a call on Tuesday that we might not have that many in queue this time.

We can probably take a couple more.

Coordinator: Okay next question comes from (Bonnie Mastarti), Farmers Insurance.

(Bonnie Mastarti): Thank you very much.

Yes I have a couple of questions but the one that's most pressing for us at the moment has not been mentioned but anyone else. I submitted it - does payment of subrogated medicals in the 12 PIP states constitute required reporting?

And the reason we ask is because it would seem that the PIP carrier would already have issued a payment on that and also an appropriate report. So we're wondering if then the liability payment of the subrogated medicals would even need to be reported at all.

Barbara Wright: The subrogated medicals as you're calling them are a liability insurance payment, correct?

(Bonnie Mastarti): They are.

Barbara Wright: Yes they'd have to be reported.

(Bonnie Mastarti): Now you're going to report from that one individual then. You're going to get a report for the PIP...

Barbara Wright: No we understand that as we've defined it - and we haven't heard anything different from the industry - PIP or Med Pay is going to end up being reported as no fault for our purposes.

And no fault is reported on one record, liability is reported on a separate record, and worker's compensation would be reported on yet a third record for the same individual. We realize that we can have multiple records and that's one of the issues that our recovery contractor is setting processes in place so that they don't end up with duplicates or separate cases.

(Bonnie Mastarti): Okay. Okay thank you very much.

I have many other questions but none that follow that one.

John Albert: Thank you.

Coordinator: Next question (Bert Anderson), (Ekin) Mutual Insurance.

(Bert Anderson): Thank you. I have a question concerning when you use the delete record. On your user guide on Page 41 and 42 and also in the example on Page 47 you basically say that if it was an erroneous HIC number, social security number, first or last name, date of birth, or gender then you would use a delete record - that is if any one of those was wrong.

On Page 50 in the bottom going over to 51 there's the sense that says "a delete transaction is only sent if the original record was sent entirely in error" which seems to imply there has to be more than just one of those things being wrong before we would use the delete record.

And I was wondering if you could clarify that.

John Albert: Yeah the reason for that what sounds on the surface as kind of conflicting statements was that when we take in another record we look at what we refer

to as the matching criteria. And the matching criteria that I mentioned I guess on Page 47 or so wherever you refer...

(Bert Anderson): Both 41 and 42 as well as 47.

John Albert: Yeah basically if you're trying to update one of those key fields it can't be updated. Because what it would - that would be treated as a new record because those five fields or so that you mentioned are not the same. So there's no way in the system to update that.

So if those key fields have to be changed you would actually have to delete and re-add that information.

(Bert Anderson): Okay that's what I thought but I wanted a clarification because it's caused some confusion here.

Thanks a lot.

John Albert: All right and otherwise, you know, for any of the other fields or, you know, if you did send smoothing in error so to speak the delete transaction would be the appropriate transaction.

Barbara Wright: Operator we can take maybe one more quick one.

Coordinator: Next question (Priscilla Linkowski), Liberty Mutual.

(Priscilla Linkowski): Hello. The question I believe you just addressed just a moment ago was if an individual is refusing to provide their social security number and it cannot be located by any other source we are at this point instructed to await your model language which may provide a safe harbor to us.

Barbara Wright: Yes. Thanks for the quick question.

(Priscilla Linkowski): Thank you.

Barbara Wright: Operator we are going to have to wind up now. Could you give us some idea of how many people dialed in and how many questions remain in queue?

Coordinator: Certainly. You had about 25 questions left in queue.

Barbara Wright: Okay and how many people dialed in?

Coordinator: You had about 1,040.

Barbara Wright: Okay the other thing if folks can still hear us I'm not sure if we remembered to say that we are in the process of setting up an additional technical town hall call each moth so that we will have at least two calls each month instead of just one - for NGHP.

So we hope that that will help us get closer and at some point get through all the ones in the queue in each call.

We thank everybody for their participation.

Coordinator: Thank you for participating in today's conference. You may disconnect at this time.

END