TRANSCRIPT
TOWN HALL TELECONFERENCE

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DATE OF CALL: October 22, 2008

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

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FTS-HHS HCFA

Moderator: Mr. John Albert
October 22, 2008
12:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen only mode. After the presentation, we will conduct a question and answer session.

To ask a question, please press star 1.

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

Now I will turn over the meeting to Mr. John Albert. You may begin.

John Albert: Hi. Thank you. My name is John Albert with the Centers for Medicare and Medicaid Services and for those on the call to confirm, this is one of our many town hall teleconferences concerning Section 111 Reporting Requirements.

For those on the call, I want to first remind everyone that this call is directed toward group health plan responsible reporting entities. If you are not - if this does not fit your responsible reporting entity definition, that means you should probably be on the call next week for the non-group health plan reporting

Q&A session. That would be for Worker's Comp, Liability and No-Fault Insurer Responsible Reporting Entities.

The purpose of this call essentially is to provide an additional allocation of time to allow people to ask questions and for us to answer. We had several calls earlier that were directed to either Group Health Plan or the entire responsible reporting entity universe out there.

And we know that we have received lots of comments through our CMS dedicated resource mailbox, as well as through the Paperwork Reduction Act. And we wanted to allow additional time for people to interact with us directly via teleconference.

Again, I will remind everyone that the questions concerning are on - at this call are to center around the Group Health Plan reporting responsibilities. For those that do not know, a Group Health Plan User Guide has been published on the CMS Web site.

That Web site again is cms.hhs.gov/mandatoryinsrep. That also has the resource mailbox that you can submit additional questions to in writing and comments as well.

That address is pl110-173sec111-comments@cms.hhs.gov. But again, that is on the Mandatory Insurer Reporting Web site that I mentioned earlier which is again, cms.hhs.gov/mandatoryinsrep. Hmm. Yes, one word.

The principal speakers today will be myself, Barbara Wright and William Decker. With that, I would like to do as we said, open up the floor to questions to continue on with the discussions based on the presentations we

made several weeks ago, and also questions about many of the new materials that are up on the Web site.

If you have not subscribed to the list service on the Web site, please do so so that you can receive notification every time we add new documentation to that site.

In the past month or so, a lot of new documentation has been put up there, but one of probably the greatest interest is to the people on this call is the Group Health Plan User Guide which has the full blown file layouts and instructions for reporting under Section 111.

With that, I would like to turn it over to the operator to start taking questions.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, press star 1. You will be prompted to record your name.

To withdraw your question, press star 2. One moment please for the first question.

Our first question comes from (Diane Poland) from CoreSource. Your line is open.

(Anne Poland): Hi. Actually it is (Anne Poland) and I had a couple of questions both related to inability to obtain a social security number.

If you have a resident alien who is potentially eligible for Medicare who does not have a Social Security number, what - how are we supposed to handle that, or if we have a participant who absolutely refuses to provide us with that information?

Barbara Wright: Well resident aliens should not be able to obtain Medicare unless they have a Social Security number. So that really should not be an issue.

The only other possibility that we can think of, and we have not been able to check yet, is whether they could have Medicare through a spouse, in which case the Medicare number would be tied to that. You would be able to get their Medicare Health Insurance claim number and you can submit either that or the SSN.

(Anne Poland): And I can understand that. However, we are not going to know if they are entitled to Medicare. They may be 65. They may be working. But we still need to submit the data. And so therefore, we are not going to have a Social Security number to put in there.

I understand that they are not eligible or they need to have that Social to be entitled to Medicare, but we do not know that. I think that is the whole intent of providing the feed. So what are we supposed to put in that place?

John Albert: Well I mean basically, without a Social Security number or a Medicare Health Insurance claim number, that does not allow us to confidently take in that data. We cannot identify if that person is in fact a Medicare beneficiary without a Social Security number at a minimum, in addition to the name, date of birth and sex code that we have in all of our intake processes through this, and any of the other processes that Medicare uses to take in other coverage data.

(Anne Poland): So we could just not send that file, that record.

John Albert: Well no. I mean, we do not want you to send it if you do not have it, but it does not - but there is still an obligation to gather that information and report it.

(Anne Poland): Unless they do not have - if they do not have a Social Security number, obviously we cannot provide it. So we should...

Barbara Wright: But you should be asking sufficient questions to determine whether or not they have a Medicare Health Insurance claim number, even if they somehow did not have a Social Security number.

We doubt that that could happen, but in the off chance it could, you should be checking whether or not they have a Medicare Health Insurance claim number. If nothing else, you may want to ask for information about any health cards they have and see those which would tell you.

(Anne Poland): So we could basic...

John Albert: Remember that for the reporting process, it is either the HICN, the health insurance claim number, the Medicare ID number or the SSN or both. If you do not have an SSN and you do have a HICN, you can still submit...

(Anne Poland): Right.

John Albert: ...the information to us.

(Anne Poland): So we can go back to them and say are you enrolled in Medicare and basically ask them to attest to the fact that they do not have any of those things and keep that on file? Would that satisfy that requirement?

Barbara Wright: That would be a prudent effort on your part. Can you hang on for just a second please?

We are back. We just had one of our other staff remind us that if someone is an employee they would have to have a Social Security number for IRS purposes for wages, etcetera, or for a dependent status.

So as you remember, IRS changed rules quite a number of years ago where even a child that is certainly no older than five, I think they have to get it at birth now, has to have a Social Security number.

So it seems like you should not really have any situations tied to employees where you do not have one number or the other.

(Anne Poland): Well, and apparently some of our clients have individuals who are from overseas but may be working in the United States for a period of time, but they could be over 45 and they are still employees.

But if they do not have a Social Security number, then a prudent effort would be an affidavit from that individual attesting to the fact that number 1, they do not have a Social. Number 2, they are not enrolled in Medicare. Is that correct?

Barbara Wright: Yes.

(Anne Poland): Okay. Very good. Thank you.

Coordinator: Our next question comes from (Carol Leaseman) from Regency Blue Shield. Your line is open (Carol).

(Carol Leaseman): Sorry. I have a couple of questions. The first one is, on the instructions it says that the MSP input file is supposed to in the first file, we send everyone, but then we only send the person again if something changes or if they should be deleted.

So for instance we would only send the person our first files, and then if they terminated coverage say ten years down the line, we would send.

How is Medicare going to make a match on these files if the person does not currently have Medicare as of that first file? Are you going to hold the information on people that do not have Medicare, because if you are, that is a HIPAA violation. You have no reason to have that information.

John Albert: No, those guidelines, which are based on the processes used in the current insurer voluntary data sharing agreement process, this is a - basically we are asking people to continue to send those people that they have not received confirmation of Medicare coverage each quarter essentially to allow that in the inst, you know, an instance where somebody attains Medicare status that we would be able to pick them up, you know, within that quarter.

I realize that there are some different processes out there right now through our voluntary data share agreement and also the voluntary data exchange agreement process, but we do not hold the data where there is no match.

(Carol Leaseman): Okay.

John Albert: Essentially we are asking people to send that record - those records that did not match to anybody to continue to send those until there is a match, which in most cases is going to be age 65. But again, you know, there are a certain percentage of beneficiaries that retain entitlement status prior to 65.

(Carol Leaseman): Okay. That is not what the User Guide says because the User Guide says that your first file will be substantially larger than any other files. And so it - and it indicates that you only have to send adds, changes and deletes on subsequent files which will not be true.

John Albert: But that is - but well, I do not have the language in front of me, but basically where - where they had, you know, here is an example. You send 100 individuals to us as adds on your first file. Maybe say 20 of them have Medicare, you know, are Medicare beneficiaries.

The next file come around, you would still need to send that balance of 80 again because on the last submission, they did not have Medicare, but they could have attained Medicare entitlement status, you know, between that past quarter and this quarter.

So you would send those same people again, assuming they still have open ongoing coverage etcetera, plus any updates to previously accepted records or in the rare instance where you sent data erroneously any delete transactions for records that we accepted and posted to common working file.

Barbara Wright: So for the individual where there was a match when you did the initial submissions, and there is not - there is a match, but they are a Medicare beneficiary and we are secondary in those situations, you do not need to resubmit that group until there is a change for those individuals.

So your file size will go down based on that unless you have a lot of new adds of course the next time.

(Carol Leaseman): Okay. And I think that it needs to be clarified in the User manual because that is not how it reads.

John Albert: Okay.

Barbara Wright: (Carol) if you have a specific page site that would help us.

(Carol Leaseman): Okay. Do you want me to send it to you Barb?

Barbara Wright: You can send it to me and Bill.

(Carol Leaseman): Okay. And then my other questions is that you have taken the stance that if our enrollment data does not match CMS's data, we have to change our enrollment data to match what CMS has.

We have groups that send enrollment data electronically to us and if I change it to match CMS data, it is - their next file is going to overlay what I have changed it to.

Is there some way we can get a document similar to what you put out for the appropriateness of SSNs and EINs, something that says if CMS's information does not match ours, that the employer is required to obtain the information as it is listed on CMS's files, which would also be SSA's files, and change their files to match that, because otherwise, this is going to be a never ending process of having to change for those people who have different names, different birthdates with us than they do with CMS.

John Albert: I mean that, (Carol) I know that that has been an ongoing issue with a lot of the current data exchange partners regarding the data that CMS uses to validate that SSN or HICN and for those that are newer to this process, again

we take in either an SSN which is what most people would have, or a Medicare Health Insurance claim number, or both, as well as the first initial of the first name, first six characters of the last name, date of birth and a sex code.

And where we are able - our matching criteria is basically three of the four personal characteristics, meaning the first last name, date of birth and sex have to match to that SSN or HICN to basically validate the match.

And where that match does occur with only three of the four, we do correct the erroneous piece of data so it is very common that for example someone may not provide you with a correct date of birth, but all the other data all would match up.

We will provide that date of birth that is from the Social Security Administration which is essentially the official Federal record of that individual. And we do ask people to use that information because again, for purposes of coordinating with Medicare and any other Federal agency, that is the official record for that person.

And unfortunately, we cannot, you know, go and make those changes with SSA. That really has to be done at the beneficiary level because if for some reason they are disputing that record, that is to say pretty much only the beneficiary can go and have that information corrected, which is why we are asking people to use the data we pass back because, again, as you have probably seen, you know, you may match on three of the four and then some point and time later on somebody goes into your system and basically may inadvertently change another one of those personal identifiers. It could result in a no match next time.

So we ask that you take the data back and we, you know, give you and use that for future updates to basically ensure that, you know, that update transaction will process correctly.

Barbara Wright: But we can...

John Albert: Yes.

Barbara Wright: ...work at an alert similar to the one we did about collecting SSNs and EINs about the types of corrections we make if you believe that will be helpful...

John Albert: Yes.

Barbara Wright: ...to you the insurers or TPA in dealing with employers.

William Decker: I would think that the employers would find that information useful, especially when it comes to...

(Carol Leaseman): Um-hmm.

William Decker: ...correcting dates of birth. But I mean everybody is different than, you know. But I mean we will pass that - that is a good idea. We can put something out to that effect that the information we are providing back should be used as, you know, a primary identifier by that employer.

(Carol Leaseman): And, you know, it could not hurt to put out the document. The big - probably more than date of birth we get people who have either changed their last name due to remarriage and never changed it with Social Security, or we have people who enroll with us using a nickname or a middle name and of course

you are matching on their legal first name, but that is not how they enroll with us. So that is the type of issue that we run into the most.

William Decker: Well we will also reinforce in whatever we send out on this issue. The fact that it is not CMS that can make these changes with the Social Security Administration, that has to be initiated by the individual who has a different name or has changed their date of birth, or for whatever reason their information does not match what SSA has on file. We cannot - simply cannot do that.

(Carol Leaseman): Right. Okay, thank you.

Coordinator: Our next question comes from Ashley Gillihan from Alston & Bird.

Ashley Gillihan: Hey, thank you for putting this on. I have a question and I may have a follow up question depending on what your answer is.

And my question is an inquiry about the application of these rules to health reimbursement arrangements as described in IRS notes 2002-45. I know back in 2005 there was guidance issued from you guys regarding the general application of the Medicare secondary payer roles to both health FSAs as well as health reimbursement arrangements.

And I know the conclusion was no as to health FSAs, yes as to HRAs and of course that has led to the, I guess the presumed conclusion that these reporting rules also apply to HRAs.

And I know at least my clients, and I represent a significant number of HRA administrators, are finding the distinction between health FSAs and HRAs difficult to latch onto that would create different treatment.

John Albert: Yes, I mean at this time, I think we have to defer an answer on that question that has come in from several people...

Ashley Gillihan: Okay.

John Albert: ...regarding the different types of accounts set up. And we do want to provide comprehensive guidance on those different types of policies.

Ashley Gillihan: Sure, sure. Well and I know you guys...

John Albert: We have received a lot of comments on - I have questions similar to that.

Ashley Gillihan: I bet. I bet. Well let me, I just wanted to throw one thing out while we are on the phone and I know you guys have a lot on your plate and I appreciate that. I just wanted to - just as you go back and analyze this, one of the things to keep in mind is with these health reimbursement arrangements, there is a significant amount of the data that you guys request as part of this reporting process that we do not get on the front end. We being the third party administrators.

We do not ask for dependent names. We do not ask for dependent data. An employee submits a reimbursement request, and it be in the employer participant's name, and 99% of the time, it is a certification that the expense that is being submitted for reimbursement was for the participant or an eligible dependent, and often times, it is not known.

And so, the data elements that are required, and I understand the reasoning behind them, will require major system changes for most HRA administrators. So I just wanted to throw that out while I had the chance to lobby.

John Albert: Okay.

Ashley Gillihan: All right, thank you.

John Albert: Have you submitted any formal comments through...

Ashley Gillihan: I did.

John Albert: Okay.

Ashley Gillihan: I did and I can resend an email.

William Decker: No if you...

Ashley Gillihan: Sorry about that.

William Decker: ...if you submitted them we have them.

John Albert: Yes, we are actually...

Ashley Gillihan: Yes, I know you had a bunch.

John Albert: ...in the process of trying to evaluate all of those comments.

Ashley Gillihan: Sure, sure I know you are.

Barbara Wright: We (unintelligible) everything to make sure that we are addressing all aspects of each of the issues.

William Decker: Right.

Ashley Gillihan: No, I totally understand. And I know you guys have a lot on your plate. I just wanted to be sure and get that out, so.

John Albert: And I also, you know, again cannot stress enough that that resource mailbox outside of the PRA comment process is always available for people to submit as, you know, more questions come up and what not. And we are always - we are very interested in hearing what people have to say because, you know, our goal is to make this as efficient as possible for all involved.

Ashley Gillihan: Well and I did submit a comment that in detail lays out why we believe there - for reporting purposes, there was not a distinction between the two accounts. And the problems that would arise, the logistical problems that would arise having to obtain this at least by January 1, so.

John Albert: Okay.

Barbara Wright: Do keep in mind that if you are a new reporter...

Ashley Gillihan: Um-hmm.

Barbara Wright: ...and not registering until April...

Ashley Gillihan: Right.

Barbara Wright: ...that then you will have your testing and there will not be sufficient until later so we are not talking about actually having the data by January 1 although you will be responsible for reporting coverage that existed as of that date.

Ashley Gillihan: Which would mean we would have to have it. And again, what my point on this was, and again I know you guys are reviewing this and I know others have questions so I will not hog this, but we do not have that data right now. And so it is a matter of actually having to change our system to get it.

And if we have to be able to report that data as of January 1 but not until later, for us, for those HRA administrators that I always represent, we are still on a pretty short, very short, almost impossible leash to get that data (bought) in.

Man: Thank you.

Ashley Gillihan: All right, thanks.

Coordinator: Our next question comes from (Amy Ledford) from Tucker Administration. Your line is open (Amy).

Man: You don't have any questions?

Woman: No.

Man: Do you have any? Okay, just a minute. We are going to defer listening to the last folks that just spoke, that kind of answered a couple of our questions.

Woman: Thank you.

Coordinator: Then our next question comes from Candi Opal from Trustmark. Your line is open.

Candi Opal: Yes. I was wondering what your thoughts are in regards to pending a claim or denying coverage if an individual actually refuses to provide us the Social Security number.

John Albert: Well, I mean, all we can say is that, you know, if they refuse to provide you with an SSN, they are essentially putting you at risk for non-compliance with the reporting requirements. That, you know, from my personal, you know, work on the VDSA program, which goes back probably almost ten years, that is pretty much made a requirement to, you know, receive that coverage. So, others have done that to basically get the SSN.

Barbara Wright: And while we cannot provide you legal advice on this, we have heard from some insurance plans that it sounds like that is their expectation. Whether or not they believe something that they can do something within the current contract cycle, certainly when they have situations that are coming up for renewal, etcetera, we have been informally told yes, they expect not to enroll people that will not give them the necessary information.

Candi Opal: All right. Thank you very much.

Coordinator: Our next question comes from (Connie Gilcrest) from Infinite Source.

(Connie Gilcrest): Thank you. My questions were all answered by Ashley's questions. And yes we at Infinite Source have submitted several questions regarding the HRAs as well. So thank you Ashley. You asked everything that we were wondering ourself.

Coordinator: Then our next question comes from (Rita Lex) from (BASF). Your line is open.

(Rita Lex): Thank you. I have two questions and it regards - first one is the Taft Hartley environment. We have participants who are covered, but they are covered as a result of working for multiple employers under the umbrella of one or two or three different employers, or they may work for one and then switch over to another.

The first question is, on the MSP input file, which employer should be reported in field 21, which is the employer tax identification number? Remember if the member is really associated or has earned that coverage through working with more than one employer.

Barbara Wright: Could you give us the second question and then we may need to take a moment to confer here.

(Rita Lex): Okay, and then my next question is if a person is 65 or 45 though 65 and then have coverage from one employer, because he works steadily for that one employer for perhaps three months, and then a second employer for the next three months, we may have him showing as two different sets of eligibility for the two different employers, but he is still covered under the plan. Is that considered a change from CMS's perspective?

Barbara Wright: Okay. Could you hang on for a second?

(Rita Lex): Certainly.

Barbara Wright: We are back. This is one of the areas we have been working on. And what we will tell you is what we are considering right now. This is not reflected in the User Guide at this time, but it is what we are looking at, is because of the types of issues you raised, we are looking at whether or not for the Taft Hartley type plans what we may require to be reported instead of the employer

name and EIN is to have the plan sponsor name and EIN reported, which I think would cover basically the issues you raised.

(Rita Lex): Okay, so I should report the employer tax ID number as the insurer ID number in both of those...

Barbara Wright: No, no, no. What we are telling you right now is do not make any final plans until we can give you the final word on this, but where the record layout currently calls for the employer name and EIN, we are considering having the plan sponsor name and EIN reported for that.

In that way, that information would be constant or current regardless of which employer the coverage had been earned through and regardless of whether the coverage was actually through an (hours) bank arrangement available for a period of time where they are not actually currently working.

(Rita Lex): Okay. I have one other question, which is the Section 111 expanded reporting option which includes Medicare Part D. Does that eliminate the need for RDS submission reporting?

John Albert: No it basically allows you as an alternative, another way to send that data to the RDS contractor. This stems back from the historical VDS safe process so that you do not have to essentially submit through two different Web portals that if you are submitting RDS files, you can use this vehicle to do so, as well as satisfy, you know, your MSP reporting obligation.

William Decker: The RDS files are just a (pasture) of this. There is no actual relationship between COB reporting and the RDS reporting. We permit, you know, in fact encourage using the non-MSP input file for RDS reporting because it is simpler for you folks.

(Rita Lex): Okay. And then just quick back to that employer, if I am using the insured's ID and the insurer ID for the employer, what do we use for the employer size in field 16 if we are not specifying an employer for that person's eligibility.

Barbara Wright: Hang on a moment.

(Rita Lex): Sure.

Barbara Wright: If you do not have information to the contrary, we believe you are going to have to assume that this type situation, there is at least one that has over 100 in the group.

(Rita Lex): Okay, so it just...

Barbara Wright: But we will address this specific issue in more detail. We are trying to nail down - your question is helpful because it helps us nail down all aspects. But we wanted to address this more fully in a later issuance.

(Rita Lex): Okay, that is fine. Thank you.

John Albert: Thank you.

Coordinator: Our next question comes from David Pittman from Zenith Administration. Your line is open.

David Pittman: Thank you. I have a question that pertains to other kinds of changes. We also deal with multi-employer plans, but that is not the only kind of thing that can change over time.

A member may go from having single coverage to family coverage and then back to single coverage, or a spouse may change from being a domestic partner to being a spouse, a legal spouse, and when those kinds of changes occur, I would like to know if we should simply report the current information of if we should have - be reporting separate periods when there are different values (unintelligible).

John Albert: Basically those would be different, separate records for the most part. If, you know, if the coverage type changes, then we need to build essentially a, you know, close out the old record and build a new record.

I mean, the business rules are, you know, in the User Guide, but in a nutshell, we are trying to build unique periods of coverage so if something about that individual's coverage changes, then most of the things that you mention, I think, would result in the need for a separate reporting record.

That is where the upstate process would occur. And so for example, you had reported coverage of somebody who had self-only coverage that, you know, that they changed it to be family coverage say at the end of June, well you would submit on your next quarter, basically an update to the existing record that would now have a termination date of the old coverage of, you know, June 30.

And then you would, at the same time, send a new add record that would include the new coverage information.

David Pittman: And the same would apply if the domestic partner became a spouse?

John Albert: (Unintelligible).

Barbara Wright: Can you hang on for a moment?

David Pittman: Sure.

John Albert: Yes, sorry. Yes, it would be a change. Just trying to remember all the business rules.

Barbara Wright: However, we also had someone here that was reminding us that the definition of spouse for the Federal government purposes it does have to be a member of the opposite sex.

David Pittman: Yes. But a domestic partner could be of the opposite sex.

Barbara Wright: Yes.

John Albert: Yes.

David Pittman: So that could still apply. All right thank you.

Barbara Wright: Yes, but we just wanted to clarify that, so.

William Decker: And I...

John Albert: House rule.

William Decker: Yes, I mean we will, I mean as we get these questions, I mean we plan on doing additional outreach and education activities to kind of drill down to these very specific issues in terms of what is an update, you know, versus a new added, etcetera, etcetera. So, you know, luckily we have a history of these kinds of questions.

David Pittman: Okay, thanks.

William Decker: Uh-huh.

Coordinator: Our next question comes from Elizabeth Wilson from Health Plan. Your line is open.

Elizabeth Wilson: Thank you. We were wondering whether it is possible to send just one file with data on all health plan members rather than segregate by age or disability status or so forth.

John Albert: You are talking about sending a full file for all of your active covered individuals?

Elizabeth Wilson: Yes.

John Albert: We do not have a problem with that. I mean...

Elizabeth Wilson: Oh - and does that...

John Albert: ...the minimum requirement is 45 and over, but I mean we already have instances where people do that and we are fine with that.

The other option is that, you know, to cut down the volume is that, you know, through this process you can query for Medicare entitlement which would allow you to maybe keep that file a little more minimum in size, but again we do not have a problem with that.

Elizabeth Wilson: And then if we did that, would that eliminate the need to extend the second file of inactive covered individuals?

William Decker: Inactive, you would.

John Albert: Well that is a different file. The inactive is for those that choose the expanded version of reporting. That is a whole other group of people. These are people that they would never be MSPs. These essentially would be...

William Decker: Yes, the MSP input file where you can send everyone that is working for you, or is a worker, actively working individual is - those are the folks that you include on the MSP input file. A non-MSP file does not have people who are subject to MSP rules, Medicare secondary payer rules, in effect. Non-MSP file is only for reporting non-Medicare secondary payer situation.

Barbara Wright: It is really help you determine if you have been paying primary, for example, or retiree...

Man: Um-hmm.

Barbara Wright: ...that you should in fact be paying secondary for. It is a special tool to help you.

Elizabeth Wilson: Okay. Thank you.

Coordinator: Our next question comes from (Wendy Work) from Highmark. Your line is open.

(Stephanie): And, this is (Stephanie) from Highmark. What I am trying to find out is (trimar) and what we had wanted to do was to send anyone under our

coverage who is 45 or older in the inquiry file, and then once that inquiry came back with Medicare information, we would then report the MSP members on our MSP file instead of having to send every single member and trying to determine if they had Medicare, if Medicare would be secondary. Would that be allowable?

John Albert: It would be allowable, but again, the reason for those that are, I mean you guys were not part of the standard insure VDSA processes. It was typically how that works.

But essentially, I mean under the law you are required to report all MSP situations to us in a nutshell. And the query file works fine in terms of assisting you in your development efforts so that you can narrow down the submission of data to CMS, but you have to keep in mind that you cannot rely on the response file from CMS in terms of whether or not that person is in fact the Medicare beneficiary if the day that you sent us to begin with did not allow us, you know, was inaccurate.

The other issue is that you also get into - you are putting yourself in jeopardy in terms of - if you are doing a two-step process, you run the risk of not meeting the data submission deadline.

Barbara Wright: If you do not do your development until you have done this query function, then depending on how long your development takes you, it might be difficult for you to meet the submission deadline. And the other thing to keep in mind is if you wish to do that query file, whether or not you narrow your file down before you do the submission for the 45 or older, keep in mind that you are still responsible for reporting Medicare beneficiaries that you know or should know who happen to be under 45.

(Stephanie): Right. And we do that. And today we do not have an age limit on any of our files that we send for MSP, but we do have a problem with how we are going to have someone in our system that does not have Medicare information yet, how we run them through our process to determine who would be primary or secondary. So...

John Albert: Yes, and we understand that and we have had lots of discussions with our current VDSA partners regarding that very issue. Some decide to do the full development for everybody or, you know, at certain age thresholds of either 55 or over or even 100% of their population, but we realize, you know, it gets down to being a volume issue when, you know, obviously the majority of Medicare beneficiaries are age 65 and over, you know, that query file is, as Barbara said, a tool that can assist you in that development effort.

But the main thing to keep in mind is that again you do run the risk of either missing people if we rely solely on your query file with us, or again, not being able to do the development timely and get the information to CMS within the prescribed timeframes.

And as you have probably seen through the record layout, one of the things that we put in the response file is a late submission indicator so that, again, you know, we can tell you that hey, this particular record came in later than the guidelines prescribed.

We will also, just as an FYI, I do not think it is out there, there is a document that will go out on the Web very soon that kind of gives it at a high level some of the milestones that if not met would put a submitter at risk for non-compliance.

But again, we encourage the GHP reporters to use the query file for not only coordinating MSP benefits with Medicare but also for assisting you all in coordinating you benefits where in fact Medicare is the primary payer, so.

(Stephanie): Yes, we were just - our MSP file today is so huge anyhow that we were trying not to put anybody more on there than we had to. So that, I understand. That is fine. We will work through that.

John Albert: Yes.

(Stephanie): I do have one more question in regards to the small employer exception field. Do we only submit those members with that field when we know that the approval has been granted, or can we - like we get a lot of notifications today from our employers that they have submitted it, but we are not sure.

Barbara Wright: You must submit the information on the person regardless of whether or not you believe the exception has been granted. What we are asking is where you believe the exception has granted, you need to affirmatively tell us that so that we will validate it against our database of such individuals to make sure we do not build a record if an exception has been granted, but you are required to report it in either circumstance.

(Stephanie): Right. We would report them, it is just whether that field needs to be completed only if we know that that has been granted.

William Decker: Do you remember what the alternative is?

John Albert: Yes, I do not.

Barbara Wright: Do you have the field number handy?

(Stephanie): I think it was like a 30...

Barbara Wright: Thirty-two something like that?

(Stephanie): Like that maybe. I know the response to us is 81, but.

John Albert: Yes, 32 is your field.

William Decker: Thirty-two, uh-huh.

John Albert: Here you go Barbara.

Barbara Wright: It says fill with spaces if there is no approval. So it is - if you know the approval has been granted, then you should be telling us that. If it has not been granted, then you should be filling it with zero.

But any employer should be telling you when they have that exception or if depending on what source of information you are setting up in terms of you as a responsible reporting entity. You really need that information to know how to pay correctly.

(Stephanie): Correct. Okay, thank you.

Coordinator: Our next question comes from Mike Cochran from Lincoln Financial. Your line is open.

Mike Cochran: Yes. I have sent in two questions via the email address and wondering if I am supposed to re-ask those in this forum or just wait until those are responded to in the - on the Web site.

Barbara Wright: Feel free to ask them and if we have an answer we will give it to you. If we are still working on it we will tell you that.

Mike Cochran: Okay, the first one was are stand alone limited scope dental plans subject to the reporting requirements? And the second one was is a supplemental health plan considered a GHP for these reporting purposes? And that supplemental health plan is basically a healthcare reimbursement insurance plan that some employers use as a perk for their key employees to pay the deductibles and other out of pocket expenses that their comprehensive medical plan does not pay.

Barbara Wright: Okay, can you hang on a second?

Mike Cochran: Sure.

Barbara Wright: On the...

Okay. With respect to the dental, Medicare in general does not cover dental services. So we are not asking for standalone dental plans to be reported. But keep in mind that if you have a situation where your dental plan covers something that would otherwise be covered by Medicare, for instance, I believe there is some limited exceptions for dental when it is tied to a traumatic injury, or for example we pay for inpatient services in connection with dental services if the inpatient services are required.

If there is a situation like that, that plan, if the group health plan rules apply, should still be paying primary. So that is the answer on the dental.

In terms of the other, it sounded to us as though you were sort of repeating the question we had had before about HRAs which we said is still under discussion. If you really meant something different than an HRA, if you could clarify that for us a little.

Mike Cochran: Yes, this is not a HRA, although I admit it is very - it is similar in it is an insurance policy actually issued to an employer who that is basically - it is sort of like the Medicare supplement policy except instead of supplementing Medicare it supplements the employer's major medical group health plan.

William Decker: Can I describe this for you and see if we have it right?

Mike Cochran: Sure.

William Decker: The employer is providing GHP and part of that - as part of the GHP that an ordinary employee would have is employee is going to have out of pocket costs for example, out of pocket expenses.

Mike Cochran: Correct.

William Decker: And the employer for key employees only, will reimburse those expenses as a condition of employment or as a, as you put it earlier, a perk of employment.

Mike Cochran: Correct.

William Decker: But not all employees would be covered by that plan, only some.

Mike Cochran: Correct.

William Decker: It still sounds to me like a HRA.

Barbara Wright: I mean, I think we have a little bit of internal disagreement here. If you would like to provide us an email to our mailbox and give a little bit more detail, it does sound to many of those, if this is a group health plan and not an HRA, then if the MSP rules apply, just because it is cast the way you have termed it as multiple types of group health plan does not mean it would not be primary to us.

If it is an HRA, then we need to answer the question in that context. So...

Mike Cochran: Yes, I did send an email.

Barbara Wright: Okay that would be great.

William Decker: Okay, thanks.

Coordinator: Our next question is from Rhonda Jones of AT&T.

Rhonda Jones: Hi, this is Rhonda Jones. And we have several questions we would like to have clarified for us. What are the benefits that VDSA versus the mandatory reporting provision?

John Albert: It is, the benefits are the same. I mean, we were offering the same...

Rhonda Jones: Okay.

John Albert: ...the same, you know, access to Medicare entitlement data that you had under the VDSA program.

Rhonda Jones: Um-hmm.

John Albert: The other benefits obviously are, you know, if we are able to make proper payment determinations sooner rather than after the fact, it cuts down on the recovery work that Medicare has to engage in with responsible reporting entities, and therefore, long term paying it right the first time saves everybody money, so.

Barbara Wright: But it is not something you need to make an assessment on because the VDEAs, VDSAs simply will not exist as of January 1, 2009.

Rhonda Jones: Okay.

Barbara Wright: There will be no choice.

Rhonda Jones: Okay. That sort of...

Barbara Wright: But everybody will be under the mandatory.

William Decker: Yes, I mean the process is very similar though. There are very few changes to the existing VDSA process as far as Section 111 mandatory reporting.

Rhonda Jones: Okay. That answers a few questions. And then clarify the reporting party for us. Is it actually the employer or the insurer as we call the carrier or group health plan, or could it be a third party in that (unintelligible).

Barbara Wright: First of all, you need to look at both the statutory language which we have...

Rhonda Jones: Uh-huh.

Barbara Wright: ...have on the Web site, as well as Attachment A which is definitions and reporting responsibilities...

Rhonda Jones: Uh-huh.

Barbara Wright: ...for the supporting statement to the PRA that is on the Web site and in general, what it boils down to, but you do need to look at the specific language and make an assessment yourself, is for GHP, if - how we define TPA is basically claims processing third party administrators. And if you are a claims processing TPA, you are going to be the responsible reporting entity.

If you are an insurer and you do not have a separate claims processing TPA, you are going to be the responsible reporting entity.

If you are an employer and you are self funded and self administered and do not have a separate claims processing TPA, then you would be the responsible reporting entity.

But please go back and look at the language in Attachment A in conjunction with the statutory language.

Rhonda Jones: Okay. So in that, would that language cover whether (voi) insure plans need to comply? Is that in the line - in the (unintelligible) language?

Barbara Wright: Whether who needs to comply?

Rhonda Jones: A fully insured plan.

Man: Fully insured plan.

Barbara Wright: Do you mean self insured or I am not sure what you mean?

William Decker: Is it - the term we are stumbling here on is fully insured.

Rhonda Jones: Is fully insured, yes. That is the plan where we are paying out like premiums to carriers to cover our participants.

Barbara Wright: Hang on just a minute.

Are you referring to excess loss type policies where you generally do not process the claims themselves, or...

Rhonda Jones: Right.

Barbara Wright: Okay. Well again, if you go back to the three definitions we gave you, it is the...

Rhonda Jones: Um-hmm.

Barbara Wright: ...claims processing TPAs that are going to be the most, probably the most frequent reporters under this with insurers being second and employers themselves being relatively rare.

William Decker: So we think our answer to you is that you probably, if that, if you (pit) that - if we understand your definition, you will not be an RRA, although we would remind you again to go back and look at the official definition.

Rhonda Jones: Right, okay. Okay, if we employ several of a multiple self-insured plans who have multiple third party claims administrators, can we designate one eligibility vendor to report all the information to CMS?

Barbara Wright: You are talk - speaking as an employer, right?

Rhonda Jones: Yes, uh-huh.

Barbara Wright: If you have a separate claims processing TPA, you are not the responsible reporting entity. Those TPAs are. If they wish to hire a joint agent...

Rhonda Jones: Uh-huh.

Barbara Wright: ...to work on behalf of them, they may do so, but they are the ones that are the responsible reporting entities, and they need to make the arrangements to do so.

Rhonda Jones: Okay, then - and they would, would they be responsible for any penalties?

Barbara Wright: The responsible reporting entities are the ones who are...

Rhonda Jones: Okay.

Barbara Wright: ...responsible for penalties. Remember they do need the cooperation of employer's plans, etcetera when they are gathering information. And as we mentioned earlier, in some cases, it is at least the anecdotal information that we have been given that insurers etcetera will start to decline to provide coverage if they do not get the information.

Rhonda Jones: Right.

Barbara Wright: But ultimately the penalty will be with the responsible reporting entity.

Rhonda Jones: Okay. And just clarify for me, when, is this a one-way reporting like from the reporting agent to CMS or will they - and they receive information back or is it just a one-way.

William Decker: It is just like the voluntary data share. You will receive response files.

Rhonda Jones: Okay.

William Decker: And that will include Medicare entitlement data as well.

Rhonda Jones: Okay. Okay. That is all I had.

William Decker: Thank you.

Rhonda Jones: Thank you.

Coordinator: Our next question comes from Larry Whitehurst of Dean Health Plan. Your line is open.

Larry Whitehurst: Thank you. One question I would like to ask point back way back to the front in talking about the Social Security numbers or the correct HIC numbers.

Our experience has been that when we have had problem trying - in other words, we know a person has Medicare. It is either based on age, disability, diagnosis, I mean it is obvious a person has Medicare.

We cannot, from the employer nor the member, get their Social Security number or get their HIC number or get their Medicare information because they just absolutely refuse it because they are scared of this HIPAA and privacy and so on and so forth.

Is there a way that this - when we contact COBC and try to get that information from them, even though we had the person's name, the person's date of birth, the person's address, the COBC replies that they cannot give that information because they do not have permission from that member to give us the data.

So, is CMS going to take a little bit of line here and give us a hand with some of these HIC numbers and Social Security numbers?

William Decker: Well unfortunately, as I mentioned earlier, without those key identifiers, we cannot - we do not have high confidence in our ability to match on that, you know, who that beneficiary is because, you know, it, you know, there is, you know, 60,000 John Smith's in the country, that kind of thing.

But I mean, you know, I guess it all goes back to that, you know, the issue of if you cannot get it why would you offer them coverage when they are putting you at risk for not complying with Section 111 reporting?

Again, that is what traditionally our approximately 200 VDSA partners that we have now, which represent a good chunk of the insured beneficiaries around the country do essentially to basically comply with the old voluntary data share agreement process.

Larry Whitehurst: So what you are telling us is, is that if these people refuse to give us the data, instead of checking with COBC to see if we can possibly come up with a match, you would tell us to tell the person we are not going to insure them?

Barbara Wright: Well we are telling you that COBC does not have the information that could give us confidence that they can match based on information that does not include the SSN or the HICN.

Some of the things we either have done or are willing to consider doing is there is an alert that is on our dedicated Web page right now that explains the need for this information, that it is appropriate for this to be collected in the context of this 111 reporting.

And that alert also says even at the bottom if they have a question about whether or not this memo is an official government document, they can go to our Web site and see that document for themselves. So that document may help you some.

In addition, we have not put it in a separate document or anything at this point, but if you want to take a look at 42 CFR 411.23 and .24, beneficiaries are supposed to cooperate in coordination of benefit situations. Also in 411.24 it says that someone who is a beneficiary by virtue of having claims submitted on them - on their behalf, they have by regulation given permission for any entity to give us coordination of benefit information which means an employer can give us the information under that regulation.

Larry Whitehurst: Okay. Two more questions real quick. The - when we send the file, if we happen to have an incorrect HICN like for example sometimes we will have the per se the spouse's HICN number, but in - that is the last data we have received. And all of a sudden the policy holder may have died. She picks up his number with a D, will the reply coming back from CMS will that give us the correct number?

William Decker: Yes, I mean we crosswalk the historical HIC numbers and we will provide you with the most recent or current HIC number.

Larry Whitehurst: Okay, and the last question, basically is the file itself - we are talking about just, and I want to just confirm that we are talking about the active employee file only. In other words, only employees that are active at work, or currently working.

Barbara Wright: You need to look at our definition of active covered individuals that is in the User Guide that spells out who you should be reporting for.

William Decker: But that is generally true.

Larry Whitehurst: Thank you.

Coordinator: Our next question is from Christina Za with Lovelace Health Plan.

Christina Za: Hello. How are you?

William Decker: All right.

Christina Za: So much for putting this on - first I have to apologize. I am very new to this. So if I ask you the questions, don't laugh.

Okay, so my very first question that I have is do you foresee any group or entities that would be exempt from us reporting? The first group that comes to mind for me is the Federal Health Benefits Program for Fed employees. Should they be included on the file format or are they excluded, or is there any other entities you see that need to be excluded?

John Albert: I guess I do not understand the question in terms of - I mean yes, I mean they would be required to report.

Christina Za: Oh, well we are a health plan and so we are going to be doing this as our fiduciary duty on behalf of our employer groups that we have as clients. And one of them happens to be where we are a carrier for the Fed, Federal Employees Health Benefit Program. So we did not - we wanted to make sure they are...

John Albert: Yes, you have to report.

Christina Za: Okay. That is (unintelligible).

John Albert: Yes.

Christina Za: Okay. And then do you foresee, I know you talk about the small group exception, we define a group as two or more covered individuals in an employer setting.

Barbara Wright: Okay. You said you were new, so...

Christina Za: Yes.

Barbara Wright: ...we will go back to that.

Christina Za: Okay.

Barbara Wright: It is not a small group exception, it is a small employer exception for employers that are in a multi-employer plan. When any employer in that plan

has 20 or more full or part-time employees, then the MSP rules apply to every employer in that plan, regardless of whether or not they have 20.

However the statute permits an exception. But in order for the exception to exist, it must be formally requested and granted by CMS. There is detail in the User Guide. There is also further detail on CMS's coordination of benefits contractors, COBC Web site, about the small employer exception.

Christina Za: And so the, the small employer actually asks for that exception on their behalf or we do not (unintelligible).

Barbara Wright: It is actually the plans that ask, or if...

Christina Za: Oh.

Barbara Wright: ...they delegated the responsibility for making the request, it is the insurer for the plan.

William Decker: The small employer itself cannot assume it has the exception.

Christina Za: Okay. So if I am hearing you correctly, you may want us to - if they do not have an exception and they are a small mom and pop shop of ten employees, we still have to report those on our list to you.

Barbara Wright: If any employer in that multi-employer group has at least 20.

Christina Za: See we have some - we do not do multi-employer anymore. We do not do associations. We are really talking about small - we are - I am in New Mexico.

Man: Excellent.

Christina Za: We are talking about small mom and pop shops that have...

Barbara Wright: If you are not in a multi-employer plan, the MSP rules for the working aged do not apply if you have less than 20 full or part time. And I think we have provided before and we could provide again the regulatory sites for how you count full or part time.

Christina Za: Okay, so that helps me. And I have other people who have helped me with that as well. Then my other question that I have is in regards to the non-compliance people who, you know, with 20 or more, we have got the information, we have asked for the Social Security numbers, and I know we have kind of beat this dead horse, but they refuse to give us the Social.

We are the ones at risk and so, if I am understanding correctly, your suggestion is that we do not enroll these individuals because they have not provided us the Social.

Barbara Wright: That is not our suggestion. That is what we have heard from the insurance industry that they expect to do. And our question would be why someone would do business with an individual that was putting them at risk for the type penalty at issue here.

William Decker: But that is...

Barbara Wright: But we cannot give you legal advice.

John Albert: Right.

William Decker: Right. That is certainly not our suggestion and please do not construe it as such. Our suggestion in that case is that you go back to the individual, take some of the documentation we have provided on the Web site, take that back to the individual and say it is in your best interest to provide us with the information we need to continue to give you coverage.

John Albert: And we are always open to suggestions regarding any other documentation that people are looking for that would help them collect that information. So...

Christina Za: Oh, okay.

John Albert: ...we have had offers of people to even write stuff for us in terms of, you know, collecting this information from beneficiaries etcetera.

Christina Za: That would be great. I would love to have some model letters.

Barbara Wright: Well, as I said, since you said you are new to it, if you have not seen it, do go back on the Web site and look at the alert about the collection of Social Security numbers...

Christina Za: I do have that and we are going to start using that. We were just wondering if there was any model letters that you had put together for, you know, requesting this information, not only from an employer group but from an individual (subscribering) member.

Barbara Wright: No we have not at this point.

William Decker: Not at this point, but we think that is a good suggestion.

Christina Za: Thank you. And so then, my next...

Woman: You are done.

Christina Za: No I have one more. My next question is that if we - just to make sure I understand the penalty assessment, so if we still have all those measures, we have done everything to obtain, and we have done our due diligence to get the socials, we still are the ones that will be penalized if we provide you a file that does not include that information.

Barbara Wright: Yes, if you provide us a file that does not include that information, we cannot accept it. We need the SSN or the HICN. So yes you are at risk if you do not have that information.

Christina Za: Okay. That is all I have. Thank you.

William Decker: Thank you.

Coordinator: The next question is from (Mike Tamarin) with Blue Cross Blue Shield.

(Mike Tamarin): Hey John. It is (Mike Tamarin). Just to clarify one thing. The FEP will be sending a centralized file with all their people in it will they not be instead of individual plans sending them through their own - through our own file?

John Albert: Will they send us an agent though?

(Mike Tamarin): Right.

Barbara Wright: Mike if you are talking about - there's an arrangement for FEP to send something directly as an agent. That would be fine if someone has made that.

But the FEP by itself, we don't believe, from our understanding of how it works, that it is a "responsible reporting entity under the statute."

(Mike Tamarin): Well I know that they just find that that's - I know they just started testing without a sharing agreement, which, you know, I guess the one file in is consumer. But we should include FEP in our reporting?

Barbara Wright: Maybe it would help you to hear it - help everybody to hear is we've had several questions like, for instance, if an employer currently has a (BDSA), but that employer is not a responsible reporting entity. That an insurer or TPA come in and say well this employer's still going to do this. So do I not have to do this?

And our answer is what another individual or entity does that's not a responsible reporting entity does not relieve the obligation of the responsible reporting entities.

If they want to work out arrangements where they're using some of these other groups as agents, or otherwise, and that's what they mutually accept - is mutually acceptable to them. That's fine for us.

But in any situation, the responsible reporting entity cannot by agreement or contract absolve themselves of the ultimate responsibility under the Section 111. They still remain ultimately responsible.

William Decker: Okay?

Coordinator: Your next question's from (Rick Ricado) with Independent Blue Cross.

(Rick Ricado): Hey John, Barbara, Bill. Good talking to you again. Thanks again for organizing this. I just have two very quick questions.

One is, once the paper registration form is submitted by the end of this month, will each healthcare carrier have a contact at CMS that we would be able to pose data-specific questions as we meet with our internal systems team to develop the file layout?

William Decker: The short answer is yes.

(Rick Ricado): Okay. Great.

William Decker: Once you register.

Barbara Wright: Then for everybody else on the line, the paper registration is solely for the people that have the current (BDSA) and (BDEA). But John's response about an (EDI) rep goes across the board.

Once you register as an (RRE), you will be assigned an (EDI) rep to help you out with all technical issues.

(Rick Ricado): Great. One other question, on the user guide, did you guys want to talk a little bit on - I believe it's Page 24 that talks about the implementation schedule? That there are some dates that may not be accurate for the time line for TINs submission?

William Decker: You received a notice about that did you?

(Rick Ricado): No. I'm just reading from the - we were recently in discussion with your team. And you were mentioning that that - the dates. But that's - I'm meeting with my team right now.

And they actually have a hard copy of the user guide. So they were pointing to me what the time line of the implementation is.

And I'm saying that it may have changed. And if it - if it is going to be changed and you're going to be submitting something on the Web site that's fine.

William Decker: Are you looking specifically at Bullet Number 2 - (pseudo TINs)?

(Rick Ricado): I'm looking at Page 24 (6.1.7).

Barbara Wright: Bullet 2?

(Rick Ricado): Yes.

William Decker: If your hard copy says January 1, 2010? January 1, 2010? It should read -say July 1, 2009. July 1, 2009.

Barbara Wright: So again, if you're a current (BDSA) or (BDEA), you do have an opportunity to transition your process where you've used some (pseudo TINs).

If you are a new reporting entity, because the deadline is July 1st, you are never going to be submitting (pseudo TINs). You must submit valid TINs from the beginning.

William Decker: Right. Again, this is a - this one's a change that we made by general announcement. I think that change went out Monday? I'm not sure. What is today Wednesday? It went out yesterday or the day before.

And it's corrected that - was essentially a couple of typos in that paragraph. We meant to say July 1st. It said - came out January 1, 2010. It should be July 1, 2009, for folks who had been already submitting TINs - (pseudo TINs).

(Rick Ricado): Thank you.

Coordinator: Your next question is from (Debbie) with Benefit Management.

(Debbie): Hello. I'd like to ask if we - we being the third party administrator for six high-risk pools. Are we considered group or non-group coverage? And how does this affect the way we would report?

Barbara Wright: From the information you've given us, we all believe that you would be a group health plan. And whoever would be the appropriate responsible reporting entity. Whether it's TPA, employer or insurer, depending on who's actually doing the claims processing. Yes it would need to be reported.

(Debbie): Okay. And then that would probably be the TPA which is us. What would we provide as the employer number since we don't really have an employer number. We have a Federal ID Number for the pool?

William Decker: Okay. Hold on a minute.

Barbara Wright: If you're not currently collecting that information on the employer - TINs. That is something you will need to arrange to obtain.

(Debbie): We have a lot of - this is the high-risk health insurance for each state. And a lot of these are individuals that are not employed. They don't have to be employed to have this. This is the high-risk mechanism that has been set up through legislature in all these states.

Barbara Wright: Hang on again. Okay. It's our understanding that you should have two general - two general categories within this. Individual enrollees and people who are enrolled through an employer - is that correct?

(Debbie): No. No. This is the Federal fall back program for uninsurables.

William Decker: Is it all individual enrollees?

(Debbie): They're all individual enrollees. Yes.

Barbara Wright: Hang on again please. For any of these, are any employers contributing toward any premiums at all?

(Debbie): No.

Barbara Wright: It doesn't sound like you have a situation that involves the group health plan arrangements subject to the (MSP) rules. If you have any further questions, put more detail in an email and we will forward it to the appropriate policy person here.

(Debbie): Okay. Thank you.

Coordinator: The next question is from (Fran Rubo) with Blue Cross Blue Shield Arizona.

(Fran Rubo): New Jersey - Blue Cross Blue Cross of New Jersey - Horizon. I just want to take you back to the FEP question that was out there by (Mike).

We also administer FEP program here. But we do not hold the enrollment. So we have no way of knowing anything about our members. We process claims based on what we call (pseudo) enrollment.

These claims have to query Washington. And Washington is the one - are the people who tell us who has coverage. Who doesn't have coverage. Who's primary? And who's not.

So I don't understand how we could be the responsible reporting entity. And (Mike)'s right. As far as we were told, Washington is looking into reporting Federal employee plan employees.

Barbara Wright: Washington?

(Fran Rubo): DC.

Barbara Wright: DC in code may be looking into it. But CMS has made no such arrangement at this time. What we can tell you is that any responsible reporting entity may use an agent.

So, it sounds like - and we're not giving you advice on this. It sounds like this may be a situation where it's in our best interest to arrange for the FEP to be the agent for actual reporting purposes.

But, under our implementation of Section 111, it is the claims processing TPA that has the ultimate responsibility under Section 111.

(Fran Rubo): Okay. So, so, in order to prove that we were compliant with this, we would have to get some kind of notification or certification from Washington, that they are going to be responsible for...

Barbara Wright: No.

(Fran Rubo): ...their own employees?

Barbara Wright: That's not what we're saying. We're saying based on the information we have, you are the responsible reporting entity. Which means you will be responsible for registering as a new reporter, when the coordination of benefits to your Web site is available for that.

And at that time, if "Washington, DC" or however you're designating this is acting as your agent for reporting purposes, then you will provide us the information that they are acting as your agent. And we would proceed from there. But again, you would still have the ultimate responsibility

(Fran Rubo): FEP's just one of the may plans that we ensure. That we process claims for. we're already, you know, (BDEA) user. But again, how could we be responsible for reporting on people when we don't have any enrollment for these people?

That's, you know, you're saying we pay the claims. Yes we pay the claims based upon information provided by in essence the employer.

Barbara Wright: What I'm doing is telling you CMS's position right now.

(Fran Rubo): Okay.

Barbara Wright: And that is that claims processing (TPAs) are the responsible reporting entities. They either need to get the appropriate information to report. Or if they're in a situation where it appears most - that easiest for them to use an agent, because they already have someone that has all this detail.

Then they may want to use an agent for reporting purposes. But they're still responsible for registering and giving us the information on who the agent is. And the ultimate responsibility under Section 11 for compliance still falls upon the responsible reporting entity.

(Fran Rubo): All right. Thank you.

Coordinator: The next question's from (Christine Epper) with Blue Cross Blue Shield.

(Christine Epper): Yes. On the 45 age requirement, and we don't have the social security numbers for all of those people yet. And we'll be in the process of obtaining those.

In the meantime, if we send those people on the file without an SSN or HICN, and there is an exact match otherwise. Will you send us the Social Security Number back so we can update our records?

William Decker: No. In fact we encourage you not to include those on file submission. Because we - they'll be rejected immediately.

(Christine Epper): Okay.

William Decker: Because we can't do anything with them.

Barbara Wright: I mean.

(Christine Epper): So you only want us to include them if we have the SSN or HICN for the 45?

William Decker: Yeah.

Barbara Wright: For the same reason that we responded earlier, that (COBC) cannot help out in this type of situation. Is we simply don't have enough confidence in any information. And we would try and match absent the SSN or HICN. That's - one of those two is absolutely critical for us to do any match.

(Christine Epper): Okay. Is there a grace period for this? I mean as long as we're showing, you know, that we're trying to obtain all this information from our existing members?

Barbara Wright: If you look at the user guide, we say there is no grace period when you're dealing with the subscriber. However, when it's a (situa) - if you already have a (BDSA) or a (BDEA), and you've got spouse or dependent that's a covered life.

You've got until the end - through the end of 2009, to get the information on the spouse or dependent. And you will still be considered compliant if all that information is submitted by the first - by your first submission in the first quarter of 2010.

(Christine Epper): Okay. Thank you.

Coordinator: The next question is from (Jonathon Hale), New York - Health New England.

(Sue O'Connor): Hi this is (Sue O'Connor). How are you? We - our question involves the reporting of active covered individuals under the relationship code.

So probably data elements in Massachusetts, because in our group health plans, we may have situations where we would be reporting legal married same-sex spouses, as well as same-sex domestic partners.

Barbara Wright: And your question is?

(Sue O'Connor): Well our question is whether that is - we had heard, you know, that there was some talk about defensive marriage (act and preemption).

But we're - in terms of just reporting those individuals, our expectation is that yes we would be reporting those data elements under the relationship code.

William Decker: Yeah I mean, I mean we need to know for purposes of Federal law whether or not they are - a spouse is defined Federally, or a domestic partner. Because the (MSP) rules apply differently, depending on the reason for entitlement.

Barbara Wright: If you're talking disability as the reason for entitlement, coverage extends to a spouse or a family member. If you're talking working (aged), it's only spouse.

So someone that we might be secondary for, while they're a domestic partner and they're under age 65, we wouldn't be secondary for once they are age 65. Because that's only for spouses.

William Decker: Can we have a little short discussion offline here please?

((Crosstalk))

Barbara Wright: To say it in a slightly different way, what we just said. If you're under 64 and you have a same-sex marriage situation, that's reported as a domestic partner.

If you have a situation where they're 65 or older, and it's a same-sex marriage situation, you're not going to be reporting it because they don't qualify as a spouse.

William Decker: Under Federal law.

(Sue O'Connor): But you're asking us to report all active covered individuals.

William Decker: Well.

Woman: Whether they're entitled or not no?

(Sue O'Connor): Whether they're entitled or not. Correct?

William Decker: I mean.

(Sue O'Connor): We're primary payer.

William Decker: No. We're asking you to look at that population and determining - and taking into consideration the (MSP) laws. That if they had Medicare, and Medicare was the secondary payer, those are the people we want you to report.

(Sue O'Connor): Okay great. Okay thank you.

Barbara Wright: Thanks.

William Decker: We're not asking you to tell us people who are (MSP) who are not (MSP). You know?

(Sue O'Connor): Yes. Yes.

William Decker: Like don't put a - for example, the (easeae). Don't put a retiree for the most part on your (MSP) file.

(Sue O'Connor): Right. Right.

William Decker: Yeah.

Barbara Wright: So that's why were saying if someone is a "domestic partner or same-sex marriage," then at 65 or older, you don't need to report them. Because we wouldn't be secondary in that situation.

(Sue O'Connor): Great.

John Albert: I mean we will again try to offer additional guidance on that. Because obviously it's generated a lot of questions.

(Sue O'Connor): Great.

John Albert: So we will go back and try to clarify through the user guide or whatever means - that process.

Woman: So we really need to go through a process of elimination? And get to the point where we just report those where we've identified as Medicare secondary?

John Albert: Well where - if they had Medicare, that would be secondary.

(Sue O'Connor): Terrific. Thank you.

Coordinator: (Brenda Wright) with (MBA). You may ask your question.

(Brenda Wright): A real quick question back to the very first original question of this forum. There are instances where aliens are in the process of trying to obtain a Social Security Number, but have not been submitted enough of the documents to be given that number.

But they do file a Federal Income Tax Return and are given an (IN) Number. Can that number be substituted for a Social Security Number in this reporting?

William Decker: The Immigration and Naturalization Number substituting for an SSN?

(Brenda Wright): Yes. When they submit a tax return - file a tax return, from working in the United States, but they are not a legal resident. They can obtain an number from the Federal Government for that submission, while they await to obtain a status to receive a Social Security Number.

Barbara Wright: (Brenda) hang on a second.

William Decker: Basically the answer to that would be to not report them until they have an SSN. But once they do have an SSN, to report that original date of coverage.

(Brenda Wright): Okay. Thank you.

Coordinator: Your next question is from (Joe Klume) with Blue Cross.

(Joe Klume): Hi. I have a few small questions here. If we're (BDEA) currently, do we still need to send everybody on our first file of 2009?

William Decker: If you're (BDEA) currently, do you still need to send everybody that you have currently covering - you've already been reporting?

(Joe Klume): Yes.

William Decker: On your first file, when you send that first file under the Section 111 process in 2009. Is that your question?

(Joe Klume): That's my question.

William Decker: If they're still covered - yes.

(Joe Klume): So even though we've reported them before - because, you know, in the past, you know, we wouldn't report them a second time. But you're saying we should?

John Albert: Well, yeah I mean, there are some additional fields that we're asking for. So yes, we would want that additional, you know, those would have to be submitted again to include those additional fields as essentially an update transaction.

(Joe Klume): Okay. I just wanted to make sure. Also, on the - well on the - I think I've gotten my (C) requirements. How do - we were discussing the FEP a little while ago. And how FEP would be our agent for the Federal employee program. This is Blue plan by the way.

And you said (unintelligible) with FEP being our agent. Well how do we register both for ourselves, and with FEP being our agent for those FEP members?

Barbara Wright: First of all you would need to make sure that you have an arrangement with FEP to be your agent.

(Joe Klume): I understand that. That's a task that I'll have.

Barbara Wright: Well, we've had some other questions. So this is partially for other people too as well. No one is automatically an agent under Section 111.

If a responsible reporting entity contracts with someone to be an agent, that's fine. And then the registration process, and there is a document available on our dedicated Web page right now, that runs through the registration process.

It asks for your information, as well as information about whoever you're using as an agent. And then we proceed from there.

(Joe Klume): Yes. But, my question is, you know, we're going to be reporting for non-FEP for ourselves.

So my real question is, I guess we just work through that once we register. They'll ask us, you know, what is your agent doing versus what are you doing?

Barbara Wright: I think Bill needs to answer this. But I believe you can register more than once for different groups that you're reporting on. Can you clarify that a little Bill?

William Decker: Yeah, I mean, yes you can.

John Albert: Yeah. Yes.

William Decker: That's true. The registration process permits you a number of - a variety of options for reporting. Including reporting by yourself and having a designated agent for other reporting.

(Joe Klume): Okay. So I would just fill out two forms and send them?

William Decker: Correct. Or even more if you wished.

(Joe Klume): Yes. Okay. Thanks.

John Albert: We're trying to allow that flexibility in terms of how people get the data to us. And recognizing especially with a larger organizations out there, that they may have data in different locations. Things like that. And we do that now currently under the (BDEA) and (BSA) process.

William Decker: We all know that this sounds daunting. We are - actually tried to make it as flexible for our partners as we can. If you have suggestions on how we might improve that, we're always looking for them.

(Joe Klume): Okay. Thank you. That's all I had.

John Albert: Operator? I think we're about out of time. Is that correct?

Coordinator: That's up to you sir.

Barbara Wright: In other words, are you saying that we can go until 3 o'clock if we wish to do?

Coordinator: If you wish.

Barbara Wright: Okay.

William Decker: Do we have the money?

John Albert: We'll keep going. I mean.

Barbara Wright: If there's still questions.

William Decker: Okay.

Barbara Wright: ...we'll keep going.

John Albert: We'll keep going.

Coordinator: Thank you. Your next question is from (Bill Monroe), American Community Mutual Insurance. (Bill Monroe) your line is open.

(Lyn Herbert): Bill had to leave. This is (Lyn Herbert) from American Community. And our question was if we register for basic - the basic reporting option to start with. Can we later register to do the expanded reporting?

John Albert: Yes.

(Lyn Herbert): Okay. So we can change later?

John Albert: Yes.

(Lyn Herbert): If we wanted to just start with basic and then do expanded later?

John Albert: Yes. And even - even if you do register with the basic. If you submit prescription drug coverage data we'll still take it though.

(Lyn Herbert): Okay.

John Albert: It's just that you have to register as an expanded reporter to receive the Part D entitlement data and response.

(Lyn Herbert): And we can do that later when we get all the information on the system that we need to do that piece?

John Albert: Yeah.

(Lyn Herbert): Okay. Thank you.

Coordinator: The next question's from (Melanie Schilling) with (Guide Stone).

(Melanie Schilling): Hi. Thank you. We have people in our plans who are foreigners. In other words, they're foreign seminary students or they're spouses of US citizens.

So we have no Social Security Number for them because they have none. And they won't have one.

Are you saying that we still - that we would be in violation if we don't report those people?

Barbara Wright: This sounds like a repeat of the legal alien situation. Where we said, if they somehow have HICN though their spouse with no Social Security Number - although we don't believe that's possible.

(Melanie Schilling): No these are not people who would have an HICN. Because they're 45, 46 years old.

Barbara Wright: Okay. First of all, are they resident or non-resident alien?

(Melanie Schilling): They would be resident aliens.

Barbara Wright: Okay. What we said before is if you have a situation like that, where they do not have a Social Security Number. And you're clear they don't have a Medicare Number. Being under 45 doesn't necessarily rule that out.

But, if it's a situation where there is no Social Security Number, I believe we said just a few moments ago, you should monitor that, unless and until they have a Social Security Number. And report them as soon as they do. Providing coverage all the way back.

William Decker: We monitor (unintelligible).

(Melanie Schilling): Okay. So we report - we only add them to the report when they get a Social Security Number or a HICN number?

Barbara Wright: Right. But report their coverage all the way back to when the coverage started.

(Melanie Schilling): Yeah. But they get to stay in our plan. Right?

Barbara Wright: We don't have a problem with that.

(Melanie Schilling): Yeah. Okay. All right. Thank you.

Coordinator: The next question is from (Judy Norwell) with Pan American Life.

(Lisa Burckhardt): Hi. This is actually (Lisa Burckhardt). And I think that you answered this question earlier. I guess we really just wanted to clarify it, so we make sure that we're understanding.

We do not currently participate in the voluntary data sharing with CMS at all. And, so our question goes to the effective date of when we need to comply.

Because this would be brand new for us. We have not created these file layouts or anything like this before. So it is completely brand new.

So, it is correct - I think I heard earlier through one of the questions and one of the answers, is that for brand new people that do not currently participate, the effective date is April 1st of next year?

Barbara Wright: Yes and no. You need to go look at the timelines that is posted on our Web site. And registration starts in April. Then there will be testing. And then you will do reporting.

But you must report the information from 1/1/09 forward when you do your first report. And if it was a covered life prior to 1/1/09, you report their coverage from the beginning.

William Decker: If it was continuous.

Barbara Wright: If it was continuous. In other words, if (John) was enrolled with you since 2005 forward, you'd report his effective date when you reported. You wouldn't just start with 1/1/09. Because the effective date of reporting is 1/1/09.

William Decker: Of that period - unique period of coverage.

Barbara Wright: Yeah.

John Albert: We're not asking you to report periods of coverage that closed prior to 1/1/09. But again, if someone has been enrolled in the same type of plan and coverage for the past couple of years, we're just asking for that effective date.

But if the registration for new people for (GHP) begins April 1, testing starts then as well. And first production files would be submitted on or after July 1, 2009.

(Lisa Burckhardt): Okay. And you said that this is in the timeline that's actually on your site?

William Decker: Yeah.

John Albert: Yeah.

(Lisa Burckhardt): Okay. And then once we do register, we would be assigned someone - I think I heard early back, that can really help us through all of this?

John Albert: Yes. An (EDI) rep. Once you go through the process and you'll receive a response from us as well. Confirming receipt of your registration, and take it from there. So yes, you will be assigned a dedicated representative to help you with the technical issues.

(Lisa Burckhardt): Okay. I'm sorry. Go ahead.

John Albert: No I was saying, you'll have a dedicated technical rep to help you with the actual file exchange process and testing and all that.

(Lisa Burckhardt): Okay. We do have a couple of people in the room listening to the conference call. And I have one other person with me that has a question. Go ahead.

Man: Kind of on the same vein. We - (unintelligible) has operations in the United States and in Puerto Rico. And through our affiliate. Would that same timeline apply to their block?

Barbara Wright: Yes.

William Decker: Yes.

Man: Okay. Well, they are - we use a third party for handling our prescription plans. And would they be responsible for reporting to - under the (MSP)?

Barbara Wright: Are you talking only for Part D? Or are you talking for something else?

Man: This is for commercial business, not Medicare business.

Barbara Wright: Is it a stand-alone drug policy or what?

Man: It's a stand-alone policy, yes.

John Albert: And that, under Section 111 is an optional reporting requirement that if - if you decide that you want to fully coordinate, you know, the commercial prescription drug plan with Medicare Part D.

You can sign on for the expanded option of this process. Which includes the ability to send to us prescription drug converge, and receive Medicare Part D enrollment data. But that is optional under Section 111.

Man: Okay.

John Albert: They encourage it. But it's optional.

Man: Thank you. That answered my question.

(Lisa Burckhardt): Okay. Thank you.

Coordinator: Our next question's from (Sheila Nelson) with WellPoint.

(Sheila Nelson): Hi. My question goes back to the original conversation. When we report people between age 45 to 64, we report them the first time, we assume they're an add. You don't find a match.

The next month or the next time that we report, we select those same individuals. Do we always send them as an add until one day you accept them? Or they terminate coverage and we no longer report them?

John Albert: You summed it up perfectly.

(Sheila Nelson): Okay. All right. Thank you very much.

John Albert: It's basically, you know, where people have that, you know, have coverage when your submission period is, you know, timeframe is - or file is due.

Include them on the file until either they drop coverage and would never be included on the file. Or again, eventually, most of them will attain Medicare status when they turn 65.

(Sheila Nelson): Okay. Thank you.

Coordinator: The next question's from (David Pittman) with (Zenith Administration).

(David Pittman): Yes. This is my second question. I didn't ask this earlier because I thought someone else might.

This is about the category of active covered individuals, that include individuals who are receiving kidney dialysis or who have received a kidney transplant.

That category has no limitations about age or employment status. And I'm really just looking for clarification that it really is as broad as it is.

So for example, if a person had a kidney transplant at age 85 after they've already been on Medicare for 20 years. Are they considered an active covered individual? Or is it really narrower than it seems to be? Can you just clarify that at all?

Barbara Wright: Could you hang on a second?

(David Pittman): Sure.

Coordinator: Our next question's from (Stephanie Williams) with Central Health Plan.

William Decker: Hold on. We were not finished with that other person yet. We were on hold for a second.

Coordinator: Sorry.

Barbara Wright: Internally we were discussing what the current process is before we replied. And yes, you should always be reporting them. And then we have further editing here that will determine whether or not Medicare is primary or secondary in that situation. As you know, there's a 30 month coordination of benefits period.

William Decker: And that determination will be transmitted back.

Barbara Wright: On the response file.

William Decker: Right.

John Albert: There actually is an indicator on the input file that - that basically is - should tell us if this person you think is (ESR). And essentially they are, you know, not - that you believe that they're (MSP) not through, you know, active work. But that, you know, there's a coordination period.

Barbara Wright: But you're right. It's very broad.

John Albert: Yeah.

Barbara Wright: Someone could have a two year old daughter that had a kidney transplant and that would be the 30 month coordination of benefits there.

(David Pittman): Well I was really concerned more about a retiree only plan, that covers only people who have no employment-relationship.

If one person in that plan happens to have had a kidney transplant, or is on kidney dialysis, then we would have to report for that plan. Just that one person.

Barbara Wright: Hang on a second. If we understood you correctly, you were saying that you believe if one person in that plan is reportable, you have to report everyone in that plan?

(David Pittman): No, no, no. I was saying - I would have to report that one person. I mean, I'm talking about - we administer hundreds of plans.

Barbara Wright: Yes. Yes you would have to report that one person.

(David Pittman): That one person for that plan? Okay.

William Decker: Okay. Thank you.

Coordinator: (Stephanie Williams) you may ask your question.

(Stephanie Williams): Yes. I wanted more clarification on the (SEE). This is new to us. So I wanted to find out is this something that the employers are asking for? Or is this something that the plan is responsible for asking for?

Barbara Wright: The plan is the one that is responsible for requesting the small employer exception. And there is a discussion about it in the user guide.

And there's several pieces available on CMS's coordination of benefits contractors Web site. In terms of the small employer exception, and how you apply for it.

And I believe we're also posting a document that makes it clear how you show proof that you've got the small employer exception. So there's a lot of information out there.

(Stephanie Williams): Okay. Fantastic. Thank you.

Coordinator: (Jeffrey Miller) with AEtna you may ask your question.

(Jeffrey Miller): Thanks. Barbara I just wanted to follow up to something you said earlier. In an existing employer voluntary sharing agreement does not exclude a - require a reporting entity from reporting under Section 11 correct?

Barbara Wright: Let's go through it once more. If you're an employer, and you have a (BDSA) or a (BDEA), and you are a responsible reporting entity, then your (BDSA), (BDEA) will no longer exist as of January 1, 2009. You must follow the mandatory process.

If you are an employer who is not a responsible reporting entity under Section 11, you may continue your current process. But that does not absolve the responsible reporting entity from reporting those same people.

(Jeffrey Miller): Okay. So I've had a customer approach me. And they state they have an existing employer voluntary program.

And they are under the impression that that excludes them from any Section 111 reporting requirements. So they don't feel they have to provide us the necessary documentation to report on their behalf. That's incorrect?

William Decker: You the insurer have the responsibility to be - to do the reporting that is required under Section 111.

(Jeffrey Miller): Okay.

William Decker: The employer is not absolved from cooperating with you simply because the employer has a (BDSA).

(Jeffrey Miller): Okay.

William Decker: Let me put it that way. Now, the employer will continue to report under the terms of its (BDSA) if it chooses to. And we see no reason why it wouldn't.

But, even though it might seem as though we were getting two data feeds with the same data under those conditions. That's not an issue for the employer to be concerned with at this point.

Okay, now if an employer has (MSP) reporting responsibilities - and we'll say that again too. All employers - the (MSP) responsibilities that all employers have had all along remain, so.

Barbara Wright: And many employers right now if they're in a (BDSA), they're primarily in it because it absolves them from data match responsibilities.

So for that reason, even if you are reporting as the TPA or the insurer, they may wish to keep their employer agreement, so that they don't have to do the data match process.

(Jeffrey Miller): Okay. Now, could I - if an employer was unwilling to provide us with the necessary details to report. Could I identify them as an agent on our behalf, to submit for the membership their unwilling to provide us the details?

Barbara Wright: We missed part of your question. But it sounds like what we said earlier. You're free to make any arrangement you want to do for an agent for

reporting purposes. But you will retain the ultimate responsibility for such reporting.

(Jeffrey Miller): So.

John Albert: If that employer - if that employer, you know, if you want that employer to be an agent on your behalf for that group of individuals. That employer will then have to submit the data under the new format, you know, prescribed for Section 111. The existing file and record layout for the employer (BDSA) would not be sufficient.

(Jeffrey Miller): Okay. So it is possible that I could identify 100 agents.

John Albert: Yeah.

(Jeffrey Miller): To report on our behalf. And they would all be responsible to meet the necessary reporting requirement?

John Albert: No.

Barbara Wright: No. You retain the ultimate responsibility for Section 1.

(Jeffrey Miller): Ultimate responsibility.

Barbara Wright: You may use as many agents as you want. And you will have to register each of them separately.

(Jeffrey Miller): Okay.

Barbara Wright: But then you retain the responsibility under Section 111.

(Jeffrey Miller): Okay.

William Decker: And all of your new agents will have to report under Section 111 data layouts, not the (BDSA) layout.

(Jeffrey Miller): That was my question. That - sorry. I mis-phrased that.

On the same lines, in the supporting statement under (Section C), the justification, Number 4 talks about the duplication of similar information. In that section, it actually refers to the (IRS) as a say data match.

And it reflects that there, you know, a possibility that that program could be eliminated or curtailed following a successful implementation of Section 111. Can you offer any guidance or timelines as to how that may occur?

John Albert: No. Not really.

(Jeffrey Miller): Okay.

John Albert: It just depends again on the success or failure of the (assessment), you know, the other - I mean CMS uses - or it's riskier to the contractor. Many other data gathering tools out there.

And you know, theoretically, if all responsible reporting entities are timely and cool on their compliance, we should be receiving very few other leads for (MSP) information through those other tools.

And so that's when we'll make that determination. But there's right now no times for that.

William Decker: We have no experience with the Section 111 reporting at this point. And we won't have enough experience with it for at least a year or two. To make - to even begin to re-examine the utility of the (BDSA), or the data match process.

(Jeffrey Miller): So as we sit today, there was - the employer's responsibility to the (IRS SSA) data match program is like it always has been?

William Decker: Correct.

John Albert: Yes. I mean the hope is - is that through, you know, when all of the (GHP) responsible reporting entities are in production and giving us data. Since we will already have built (MSP) records where (MSP) exists, that the volume of questionnaires that employers ought to receive would go down, so.

(Jeffrey Miller): Okay. Just an FYI. I believe you may have distributed documentation to employers in September announcing the new electronic process for the (IRS) match. I believe employers are beginning to confuse that with Section 111.

John Albert: Okay.

(Jeffrey Miller): We're getting requests from our customers. Actually they're forwarding your letter to us.

John Albert: Okay. Well we appreciate that.

William Decker: Yeah that's actually interesting to know. Thank you very much.

(Jeffrey Miller): One last question. On the registration document under the submission profile information, it talks about the estimated number of covered individuals. And the estimated number of covered individuals age 45 and over.

When would that number be appropriate? Understanding that, you know, you've extended to 2010 for the collection of the dependent Social Security Numbers for existing book of business.

Would I provide that number? Or do I anticipate the ultimate (MSP) volume to be? Or would I anticipate our first quarter file in '09 to be?

William Decker: The numbers for us for planning purposes, it's not a number that we would expect necessarily to be actually accurate down to the - one or two individual level.

We would ask you, and anyone else, to give us information that will help us plan the volume of - plan for the volume of information that might be coming in from you. Either now or when you actually believe you'll be in full production.

(Jeffrey Miller): Okay.

William Decker: And that's the actual number we're looking for.

(Jeffrey Miller): Got you.

John Albert: We want to distribute the work across each quarter. So that, you know, we can maintain a high level of customer service. And make sure there are no bottlenecks between the, you know, with the very large insurers and the much smaller insurers.

(Jeffrey Miller): Okay. Very good. Thank you very much.

John Albert: Operator? About how much time do we have left?

Coordinator: Well it's approximately four minutes until the top of the hour. I'm not sure how much longer you wanted to go. You can - it's up to you.

Barbara Wright: Do you know how many questions you have in the queue?

Coordinator: Let me see. There are probably about 25 still.

Barbara Wright: Could you hang on a second?

Coordinator: Sure. Of course.

Barbara Wright: We believe that we're going to have to stop at 3:00, operator. We have other commitments here.

Coordinator: Okay. So did you want to take one more question?

Barbara Wright: Sure.

Coordinator: All right. Then our last question comes from (Chuck Thornton) of Integrity Associates. Your line is open.

(Chuck Thornton): Hi. Actually boy, as I've been waiting most of my questions have been answered. Although one I guess sort of has come up sort of in relation to - you were talking about immigration and stuff like that.

We've had something come back where we've had like an employee who's got a (soc), but he's got two dependents on the plan. Either because they were living in another country and then joined him later.

And now - so he's an employee. He's got a (soc). But he's got two dependents who don't. Do we just - I mean, how does that work?

John Albert: I mean, if they don't have Social Security Numbers, they're dependents and they wouldn't be submitted on that file until such time they got Social Security Numbers.

Barbara Wright: Pretty much the same answer we gave before.

John Albert: Yeah.

Barbara Wright: Monitor it. When they get a Social Security Number, then include it if appropriate.

But if you're talking young children, those are the ones that you're going to be making the individual determination whether or not they're a Medicare beneficiary anyway. They're not part of the 45 and older, where you're routinely submitting everybody.

(Chuck Thornton): Got it. So and weird case, where we're not the data exchange partner. We're, you know, we've got an insurance company that's actually doing that.

But they - be cause they've never collected dependent Social Security Numbers before, they're, you know, they're coming in now and trying to get them from us - the employer group.

And we're helping them gather them and stuff like that. And in this particular case, actually one of the people is an adult spouse. But, so, if they're going to - I guess they're going to report it.

And they're going to report the covered individual. Are you saying that the insurance company would leave the covered individual off of the file that's got the (soc)? Or they would still report it?

Barbara Wright: No, no, no. The subscriber who has the Social Security Number, you would still be reporting them. What we're saying is if you have a dependent or spouse - in either case, even if it's a subscriber. If they don't have an SSN yet, or a HICN, then there's no way that you can report them to us.

William Decker: They have to have one or the other in order for us to try to make a match. So if you have neither, an SSN or a HICN, that's the general rule. If you have neither of those, don't send it in.

(Chuck Thornton): Got it. Okay. Well we'll call that - I'll draw that to their attention then, so. Okay. Thank you.

William Decker: Okay. Thank you.

Barbara Wright: If everyone who didn't' get their question asked, if we haven't answered it, if you could please submit your questions to our public comment mail box. And if you haven't used that before, the address is pl110-173s - as in Sam - e as in elbow-...

Woman: (Unintelligible) tell me to have her do it. She leaves at two.

Barbara Wright: C - as in cookie...

Woman: Go ask her to do it.

Barbara Wright: ...- 111-comment@cms.hhs.gov. Someone here was saying - that last interruption should make for an interesting bi-play in the transcript.

Operator I think that's it for us. We thank everybody for participating.

Coordinator: Thank you.

END