Dear Medigap Insurer:

MEDIGAP CLAIM-BASED CROSSOVER MOVES TO A CONSOLIDATED, STANDARDIZED PROCESS.

This announcement is to inform you that, effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will transfer the mandatory Medicare supplemental (Medigap) insurance claim-based crossover process from its Medicare contractors to the national Coordination of Benefits Contractor (COBC). The definition of a "Medicare supplemental (Medigap) policy" is found at §1882(g)(1) of the Social Security Act, the text of which is being attached for your reference. The Medigap crossover process is mandated by §1842(h)(3)(B) of Title XVIII of the Social Security Act and is activated when 1) a participating Medicare provider includes a specific identifier on the beneficiary's claim and 2) the beneficiary assigns payment rights to that provider.

WHAT DOES THIS MEAN TO YOU?

The CMS is expecting your organization to contact the COBC during June 2007 regarding your need to sign a national Coordination of Benefits Agreement (COBA) that will enable you to continue receiving Medigap claim-based crossover claims. You may reach the COBC for this purpose by dialing 1-646-458-6740. The executed COBA will address claim transfer protocols, the frequency of the claim transfers (available options include daily, weekly, bi-weekly, or monthly), and the standard crossover fee. After your organization has signed the COBA, you will be assigned a new 5-byte COBA Medigap claim-based identifier. All participating providers will then have access to the Medigap insurer's new COBA Medigap claim-based identifier prior to October 1, 2007, and will be required to include this new identifier on your policy or certificate holders' incoming Medicare claims to successfully trigger mandatory Medigap claim-based crossovers.

With the transition of the Medigap claim-based crossover process to the COBC, Medigap insurers will enjoy the benefit of only needing to interact with one entity when they have questions or concerns. In addition, the Medigap insurers will now receive their claims and invoices from a single entity rather than individually from numerous Medicare contractors across the nation.

Effective October 1, 2007, CMS will discontinue the use of all non-standard claim formats, including National Standard Format (NSF) and paper claims. As "covered entities" under the final Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule, Medigap insurers must be able to accept the standard HIPAA American National Standards Institute (ANSI) X12-N 837 professional coordination of benefits (COB) version 4010-A1 claim. In addition, your organization should be able to accept National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 Part B drug claims. However, CMS is **not** mandating receipt of NCPDP batch standard claims at this time. CMS will advise your organization when acceptance of these claims is required. Therefore, effective October 1, 2007, your organization will receive Part B physician and supplier claims in the HIPAA ANSI X12-N 837 professional claim (with receipt of NCPDP batch standard claims to follow in the future). In accordance with volume 55, number 225 of the November 21, 1990, *Federal Register Notice,* CMS will exclude non-assigned, fully paid original and fully paid adjustment claims, fully denied original and fully denied adjustment claims, and non-monetary adjustment claims from its national COBA Medigap claim-based crossover process with your organization..

Medigap insurers will continue to receive their crossover claims from their associated Medicare contractors at their currently designated frequency and in their currently designated claims format during the interim period from June 1 to September 30, 2007. Until October 1, 2007, the only change to the current Medigap claim-based process is that the Medigap insurer will be replacing its current identifier that initiates claim-based crossover to the 5-byte COBA Medigap claim-based identifier for processing purposes. This change will occur shortly after execution of the COBA.

WHAT CAN MY ORGANIZATION DO TO BE PREPARED FOR THE OCTOBER 1, 2007, CHANGE?

Since your organization will no longer receive Medigap claim-based crossovers from CMS' Medicare contractors effective October 1, 2007, CMS strongly encourages all Medigap insurers that are currently receiving their crossovers via this methodology to act now and contact the COBC at 1-646-458-6740 to obtain more information about signing the national Coordination of Benefits Agreement (COBA). Your COBA will need to be signed during the months from June to August 2007, to allow your organization sufficient time for testing with the COBC in advance of the October 1, 2007, implementation. In addition, since Medicare will exclusively be crossing claims over to your organization in the standard HIPAA ANSI X12-N 837 professional claim format effective October 1, 2007, your organization may need to consider planning now to contract with an outside vendor that is able to accept the standard HIPAA claims format on your behalf.

Upon receipt of your COBA Medigap claim-based identifier, your organization should initiate provider and member education on the use of the new identifier. CMS recommends that, in accordance with §1882(c)(3)(C) of the Social Security Act, you consider issuing new cards to your Medigap policy and certificate holders that inform them of the new COBA Medigap claim-based ID for your organization. This will assist

your policy or certificate holders with ensuring that their providers include the correct number on their incoming claims to Medicare. In addition, Medicare will be conducting extensive provider education concerning the new COBA Medigap crossover process through its Medicare contractor provider communication channels and websites.

If your organization currently provides an eligibility file to initiate COBA Medigap crossovers, you may simply add all policy or certificate holders to your COBA eligibility file and maintain your current COBA identifier. In addition, please contact your COBC EDI or CMS representative for information on discontinuing your current Medigap claim-based crossover contract(s) with the Medicare contractor(s) if applicable.

WHAT OTHER DETAILS SHOULD MY ORGANIZATION KNOW?

Effective with claims received after your COBA has been executed, your previously assigned Other Carrier Name and Address (OCNA) or N-key Medigap identifier will no longer be accepted on participating provider claims as a basis for triggering the crossing over of adjudicated claims to your organization. Also, unless your organization has executed a COBA with the COBC prior to October 1, 2007, your organization will be unprepared to test the new process with the COBC and, consequently, will be unable to receive production claim-based crossover claims following the implementation of the new process on October 1, 2007.

Starting October 1, 2007, claims will exclusively be selected for crossover to your organization through the new COBA Medigap claim-based crossover process. CMS' Medicare contractors will cease crossing claims directly to your organization. In addition, all current Medigap claim-based crossover recipients are advised that CMS' Medicare contractors will automatically terminate any existing crossover agreements with your organization no later than October 31, 2007, following your receipt of the final or residual claims that were tagged for crossover directly from the Medicare contractors prior to October 1, 2007.

If your organization has already signed a COBA with the COBC to participate in the eligibility file-based crossover process but you wish to continue receipt of claim-based crossovers for a portion of your policy or certificate holders, your organization will need to sign a new COBA (base agreement and attachment) to address your receipt of claims via the COBA Medigap claim-based crossover process.

The CMS and its COBC look forward to working with your organization to ensure a smooth transition from your current Medigap claim-based crossover process to the consolidated COBA Medigap claim-based crossover process.

ATTACHMENT A—Additional Information

Definition of a Medicare Supplemental (Medigap) Policy

In accordance with §1882 (g)(1) of Title XVIII of the Social Security Act, a ***Medicare supplemental policy*** is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.