W. R. Berkley Corporation
475 Steamboat Road
Greenwich, Connecticut 06830
Tel: (203) 629-3000 • Fax: (203) 769-4097

September 29, 2008

VIA Email PL110-173SEC111-comments@cms.hhs.gov

The Honorable Mike Leavitt
Secretary
U.S. Department of Health
& Humans Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Comments CMS & Medicare Secondary Payer (MSP) Reporting (MMSEA) (P. L. 110-73) (42 U.S.C. 1395y (b) (7) & (8) CMS 10265 Federal Register dated August 1, 2008

Dear Mr. Secretary:

W. R. Berkley Corporation, a Delaware corporation and insurance holding company, owns and operates several insurance companies which will be affected by these rules. We appreciate the opportunity to make comments on the rules released in Federal Register dated August 1, 2008.

The following comments relate to the "Supporting Statement for the Medicare Secondary Payer (MSP) Mandatory Insurer Reporting (MIR) requirements of Section 11 of the Medicare Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) (42 U.S.C. 1395y(b)(7) & (8) (CMS – 10265)" document, issued in Federal Register dated August 1, 2008

Comments and concerns are noted in *italics*. Otherwise text reflects the statement made in the above referenced document.

C. Justification
6. Collection Frequency (Page 6)
The rules state that collection of data will be no more than quarterly. *This statement is not terribly definitive. We believe it would be helpful to refine and state a definite timeline by type of claim.*

For example the rules state, "GHP data will be submitted by the GHP entity on an ongoing basis". This appears to be inconsistent with "no more than quarterly" and unclear as to how often insurers will need to report.

Additionally, CMS rules state that Non-GHP data will be submitted on an "ongoing basis" for No-Fault insurance and workers compensation for non-contested claims and on a one time basis for contested cases where there is a single settlement, judgment, award, or other payment." *Again, this appears to be*

inconsistent with "no more than quarterly" and unclear as to how often insurers will need to report by type of claim; contested or non-contested.

These "frequency" statements by CMS continue to be confusing as to the timing of reporting. Insurers need a more definitive answer on precisely when companies will need to report so companies can set up processes – how often companies will be required to report by line and type of claim. Every time there is an update to an "on-going" file or quarterly? It is unclear as to reporting for final or settle claims? Is it when cases are final and settled or by a certain time quarterly or some other time?

Page 7

8. Federal Register Notice/Outside Consultation
Listening/Outreach Sessions
We have some concerns as it relates to acquiring Social Security Numbers ("SSNs"). Our question is *how does the reporting entity ensure accuracy of the SSN reported; see Attachment B discussion.*

Page 9

12. Burden Estimate (hours and wages)
Under Non-GHP's
The rules at the 2nd paragraph on page 9 – references Attachment "C" and should read Attachment "D".

Page 10

12. Burden Estimate (hours and wages)
Under Non-GHP's
The rules at the 5th Paragraph 2nd bullet point on page 10, appears it should read "non-GHP" since this is the section on non-GHP, rather than GHP.

Attachment A – Definitions and Reporting Responsibilities
For Non-GHPs
The rules, under Attachment A page 13, defines insurer as a liability insurer or no fault insurer as an entity that in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims process; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y (b) (8) regardless of whether it uses another entity for claims processing.

Specifically under 41 CFR 411.50 Liability is defined as:

> Liability insurance means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, *homeowners' liability insurance*, malpractice insurance, product liability insurance, and general casualty insurance.

Our question is if homeowners' liability is included in the definition of liability, is it true that commercial property or commercial mulitperil policies, which can both include property coverage, would also be included in the required reporting? If so, how will they be distinguished under the reporting as outlined?

Further, it appears that CMS's definition within their proposal (not 41 CFR 411.50) [of liability] is really more of a general description of insurance, rather than liability insurance. We believe it would be in the best interest if CMS would more accurately define "liability insurance." In a Dictionary of Insurance 1979 edition, "Liability insurance is defined as a form of coverage whereby the insured is protected against injury or damage claims from other parties. Any form of coverage whereby the insured is protected against claims of other parties from specified causes."

Further," Liability insurance, and more specifically, bodily injury, is defined as, "insurance against loss due to claims [as it relates to bodily injury] for damages because of bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time."

The CMS definition addresses claims generally; however it doesn't differentiate between bodily injury and property damage, which would be crucial for the applicability to the MIR.

We respectfully recommend use of an industry standard for these terms from a dictionary of insurance terms or the Chartered Property and Casualty Underwriter.

The rules, under Attachment A, page 13, Claimant is defined as 1) an individual filing a claim directly against the applicable *plan*, 2) an individual filing a claim against an individual or entity insured or covered by the applicable *plan,* or 3) an individual whose illness, injury, incident or accident is/was at issue in 1 or 2.

We would recommend the replacement of the word "plan" with "policy" as P & C insurers generally use the term policy. Further "Plan" could imply group insurance and P & C is not necessary sold on a "group" basis but rather on an individual or company entity [insured] basis. Even when a group policy is sold in P & C, it is generally not referred to as plan.

Also the Dictionary of Insurance defines claimant as, "an individual asserting a right or presenting a claim for a suffered loss. One who makes or presents a claim."

*We believe it would be important to include "**asserting a right for a suffered [bodily injury] loss or other loss requiring medical attention**," within the definition, as this would be crucial to this definition.*

The rules under Attachment A, page 13, CMS defines no fault insurance. We understand that CMS believes that their definition of no fault is controlling as found in 42 CFR 411.50, which reads:

> No-fault insurance means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, *homeowners, and commercial plans*. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

Our question is one of clarification, under the definition of no fault above, no fault in general includes benefits for [bodily] injury related expenses such as medical costs, loss of wages, compensation for loss of services, funeral expenses, and death benefits. So by this definition, does CMS mean to include homeowners and commercial property and commercial multiperil policies as it relates to "no-fault" or automobile policies only? Typically in property and casualty, no fault is a term used to refer to automobile policies.

The rules under Attachment A, page 14, states the definition of liability self insurance as, such deductibles and co-payments which constitute liability self insurance, and require reporting by the self insured entities. However in order to avoid two (2) entities reporting with possible confusion where the deductibles and or co-payments are physically being paid by the insurer or its TPA, CMS is considering requiring such deductibles and co-payments to be reported as a part of the insurer or TPA's report

CMS asks if carriers would prefer to simply report once for insurer and insured – we would vote, YES to report both as it relates to the insurer information and as it relates to the deductible information, as ultimately, we believe, this would lead to a clean efficient system.

Attachment B
Need for SSNs or Health Insurance Claim numbers

Essentially even though state and federal laws may restrict when SSNs can be collected and how SSNs can be used, the state initiatives do NOT preempt the MSP statutory or regulatory provisions or the "permitted use" provisions of the HIPPA privacy rules. Bottom line, collection of SSNs for the purposes of coordinating benefits with Medicare is a required, legitimate and necessary use of the SSN under Federal Law.

Our concern is how we can obtain the SSN if the injured party refuses to provide or provides an inaccurate number – do we need or can we require completion of a form that is signed (essentially acknowledged as being accurate) by this party?

Attachment D
Applies to non-GHPs

It appears that CMS copied Attachment D in its entirety from Attachment C – essentially treats P & C like A & H. It may be necessary to differentiate GHP required data from non-GHP required data since A & H insurance companies generally operate differently than P & C insurance companies.

Data elements we *may not* collect at this time and will need a process for collecting and inputting are:

Injured party (the injured party is/was a beneficiary)

Email
Date of birth
SSN
Beneficiary HICN

Claimant -In addition to the above (under injured party) insurers would also need:

Beneficiary relationship (not typically collected in the course of a P & C claim file).
Name and address
Telephone and or email
TIN (SSN or EIN)

Insurers need clarification whether they would need to report each claimant separately when there are multiple claimants tied to a single occurrence or event and what process CMS would want to see for reporting such multiple claimants? For example we may have multiple unrelated claimants that were injured in one occurrence under a liability or automobile policy?

Primary Plan (separate report for each plan and or insurance type), *again we would ask that CMS refer to this as "policy" since this is P & C insurance.*

This seems to imply that we only have to report bodily injury settlements on a primary [policy] basis not an excess [policy] basis? We request confirmation from CMS of whether we need to only report primary policy claim payments or whether we also need to include excess policy payments as well.

Under CMS rules Attachment D, page 18, 17. Name – we are not sure if reference to name is for the name of insurer or name of policyholder; please clarify.
TIN (SSN or EIN) of insurer or insured? Again, please clarify.

20. Additional information
CMS would need to let us know with sufficient time in advance as to what this is to ensure insurers can capture such information in our systems.

Attachment D continued page 19
Incident
34. Date of injury. CMS attempts to clarify what is meant by "Date of Injury". As it relates to "exposures," *wouldn't the date of first exposure; be clearer if it read, "first known exposure" for claims such as asbestos?*

35. Nature of injury.
This item references a WCIO (nature of injury) table. *Please note, that non work comp insurers may not be familiar with these tables. It may be helpful for insurers if CMS would more clearly define where this table is available from or provide a source for it.*

36. Cause of injury.
This item also references a WCIO (cause of injury) table. *Please note, that non work comp insurers may not be familiar with these tables. It may be helpful for insurers if CMS would more clearly define where this table is available from or provide a source for it.*

37. State of venue
ICD-9 code (up to 5 occurrences) – (requires at least 1 ICD-9 code or body part code).

We are not sure that P & C insurers are familiar with ICD codes. It may be helpful if CMS more clearly defines where this information is available from or provide a source for it.

39. Body Part (up to 5 occurrences)
WCIO body part code table; at least 1 body part code or ICD-9 code.

Note, that non work comp insurers may not be familiar with these tables. It may be helpful for insurers if CMS would more clearly define where this information is available from or provide a source for it.

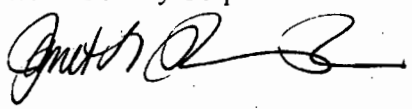
Other Questions/comments:
Although this is effective July 1, 2009 for P & C insurers, as of what date will data have to be transmitted. If a P & C insurer has an open claim as of July 1, 2009 will such insurer have to go back and gather this data on this claim?

Will P & C insurers have to report on claims closed prior to July 1, 2009 but before January 1, 2009? Or just anything open as of July 1, 2009 which could include multiple years?

We are in favor of electronic reporting and would like to see if we can position ourselves for automated compliance, rather than data entry when a person logs on to the CMS system. Will this be possible?

Thank you very much for this opportunity to express our thoughts. Should you wish to contact us for any clarifications, please feel free to contact the undersigned at 1-800-842-8972 ext. 4045 or via email at jshemanske@nautilus-ins.com. To respond via U.S. Post Office, the physical address for the undersigned is 7233 E. Butherus Drive, Scottsdale, AZ 85260.

Sincerely,
W. R. Berkley Corporation



Janet L. Shemanske
Assistant Secretary

PARHAM, WILLIAM N. (CMS/OSORA)

From: Wind, Donald C [Donald.Wind@bnsf.com]
Sent: Thursday, October 09, 2008 10:24 AM
To: CMS PL110-173SEC111-Comments
Subject: #215 [NGHP- WCIO Codes]- Comments on the use of WCIO injury description codes to report

During the 10/1/08 conference call, Barbara Wright asked for feedback on the use of WCIO codes to report the injury description. Because so many different industries will be reporting, there is unfortunately no one set of codes that we are all currently using. This will create ongoing duplicative efforts for those of us that do not currently utilize WCIO codes.

My thought is that the only way around this situation is to report the injury description using freeform fields, something like the following:

- Describe cause of injury – 40 bytes
- List body parts injured – 20 bytes – up to 5 body parts
- List nature of injury – 20 bytes – up to 5 descriptions, corresponding to body part

This would allow everyone to report without creating duplicate work and still provide CMS with the required information. The downside would be the lack of exact uniformity between the RREs. Thus, this option is far from a perfect alternative, but is perhaps the only other alternative. I thought I would submit my thoughts, for what they are worth…

Thanks for your efforts to define requirements as much as possible. When any of the Medicare compliance areas lack definition, everyone is put in a situation that makes it difficult to understand how to fulfill our obligations.

Don Wind

BNSF Railway

817-352-2331

PARHAM, WILLIAM N. (CMS/OSORA)

From: Angela Mckinney [Angela.McKinney@sharp.com]
Sent: Thursday, October 09, 2008 11:52 AM
To: CMS PL110-173SEC111-Comments
Subject: #216 [Other- Teleconference and reporting requirements]- Comments on SECTION 111

Unfortunately we missed the open door forum that was scheduled 10/01/08

Will there be another one scheduled
We need more information needed on this requirement posted to the website
How do I know if my organization is required to report – Am I an RRE?

Please advise or direct me to further information than the website which does not answer these questions, and many more provider's have

Thanks
Angela McKinney
Sharp HealthCare
858-499-4218

PARHAM, WILLIAM N. (CMS/OSORA)

From: alockridge@cameron-insurance.com
Sent: Thursday, October 09, 2008 12:47 PM
To: CMS PL110-173SEC111-Comments
Subject: #217 [NGHP- claims reporting] Question from NGHP liability insurer: Which claims are required to be reported?

We are a NGHP, liability insurer. Could you please clarify if you would require all liability claims with medical damages involved to be reported under these regulations? Or just a particular subset meeting age requirements, etc.?

Thank you.

Andrea L. Lockridge
General Counsel and Assistant Secretary
Cameron Mutual Insurance Company
816-632-6511

PARHAM, WILLIAM N. (CMS/OSORA)

From: Lou Ann DeLong [ladelong@CentralPaTeamsters.com]
Sent: Monday, October 13, 2008 8:13 AM
To: CMS PL110-173SEC111-Comments
Subject: #218 [Other- SSN and HICN] SS vs/ JOCFA

We only have SS of participants/dependents. Do you require HICN numbers?

PARHAM, WILLIAM N. (CMS/OSORA)

From: foxak@gabrobins.com
Sent: Monday, October 13, 2008 9:15 AM
To: CMS PL110-173SEC111-Comments
Subject: #219 [Other- RREs and agents] Sec 111 Reporting Question Regarding RRE and TPA

As a TPA, we do business for over 500 RREs. Will each RRE that designates us as their agent be given a different "start" date? What about testing dates?

Katie A. Fox
Compliance & Resolution Manager - MSP (Medicare Secondary Payor) MedInsights
17011 Lincoln Ave. #516
Parker, CO 80134
720-219-9904
Fax 720-842-1805

PARHAM, WILLIAM N. (CMS/OSORA)

From: foxak@gabrobins.com
Sent: Monday, October 13, 2008 9:25 AM
To: CMS PL110-173SEC111-Comments
Subject: #220 [NGHP- claims reporting] Question Re: claim inventory to be transmitted Sec 111 Reporting

As a claims organization, many files close from a procedural aspect upon recovery of the claimant/plaintiff. In WC many jurisdictions have lifetime medical benefits. Meaning that the claim will closure due to the recovery of that person, but there is not settlement judgement or award.

With this being said, what claims are expected to be captured as of 7/1/08, to be reported upon RRE time period assignment, open active claims or both open and closed for jurisdictions where there is lifetime medical benefits but the person has recovered?

Thank you!

Katie A. Fox
Compliance & Resolution Manager - MSP (Medicare Secondary Payor) MedInsights
17011 Lincoln Ave. #516
Parker, CO 80134
720-219-9904
Fax 720-842-1805

PARHAM, WILLIAM N. (CMS/OSORA)

From: Mary Ellen Haynes [MEHaynes@MEDCOST.com]
Sent: Monday, October 13, 2008 10:42 AM
To: CMS PL110-173SEC111-Comments
Cc: Mary Etchison
Subject: #221 [Other- RRE registration and timeline] Questions for 10/22/08 Teleconference

1. We are a TPA that will be a new reponsible reporting entity (RRE) which means we would register on-line in April 2009. Do we register one time only, or is it necessary for us to register for each of our client group health plans?

2. We are a TPA that will bea new responsible reporting entity (RRE) which means we would register on-line in April 2009. We understand that entities that have already been reporting under the old MSP program, and who have a Voluntary Data Sharing Agreement (VDSA) with CMS are to register by paper during the month of October 2008. We have client group health plans who currently have a VDSA, however, as their TPA, under these new mandatory reporting requirements, we will assume the reporting responsibilities for them. In these situations, are these plans required to do anything about registration?

3. We understand the timeline for the registration and testing process. Do you, at this time, have a file layout? If not, when do you anticipate being able to provide this?

4. We understand the timeline for testing and the submission of the first production file. Please clarify.....though this first production file will be submitted sometime around October 1, 2009, is this file to report data on all individuals who meet the Medicare eligibility (as defined) on January 1, 2009 and thereafter? Versus, those who meet the eligiblity requirements on October 1,, 2009?

Thanks!

Mary Ellen Haynes
Compliance Manager
MedCost Benefit Services
145 Kimel Park Drive
Winston-Salem, NC 27103
Phone: (336) 774-4169
Fax: (336) 970-2109

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Glenn Hansen [Glenn.Hansen@multicare.org]
Sent: Monday, October 13, 2008 10:48 AM
To: CMS PL110-173SEC111-Comments
Subject: #222 [Other- Claims reporting] Washington State

I am confused about the reporting for Washington State Claims. We don't have C & R arrangements or other types of medical settlements. We do have opportunities to settle claims at the Board of Appeals, but most often these do not involve medical, more often they are nuisance settlements or agreements to segregate conditions in exchange for $$.

Claims processing involves allowing a claim, treating to MMI, and closure with a 7 year window for reopening if there is objective worsening.

My questions then are:

1. In the narrow sense of settlements we have, what settlements would be reportable under Mandatory Reporting?
2. Is there a monetary threshold for what should be reported?
3. What about claims closed if the reopening window still exists as a possibility?

Glenn Hansen
Workers' Compensation Manager
MultiCare Workers' Compensation Department
PO Box 5299, M/S 19U-A3-WC
Tacoma, WA 98415
Phone: 253-459-6803
Fax: 253-459-6815
Email: glenn.hansen@multicare.org

MultiCare

BetterConnected

"MMS <multicare.org>" made the following annotations.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Wood, Michael S [Michael.Wood@esis.com]
Sent: Monday, October 13, 2008 11:40 AM
To: CMS PL110-173SEC111-Comments
Subject: #223 [Claims reporting] Reporting Requirements

Good Morning,

I have a question re the reporting requirements. It's my understanding that reporting is required on all accepted claims, i.e. all claims where payment has been made at the onset of the claim and at the time of closure (Regarless of the claimant's age, medicare status or severity of the claim). Also, reporting to CMS is to be done on a quarterly basis and that the proposed reporting doc is 3 pages consisting of approximately 44 questions. The reason I'm asking the aforementioned questions is because I've received conflicting info from other sources re the reporting requirements (ex: reporting is only required for claimants who are medicare eligible due to age, or who have filed for SS/Medicare).

ESIS claims are managed in a paperless environment. Please send all correspondence and medical bills to the appropriate scanning center listed below, and be sure to include the claim number on each document. This will help speed the processing of the claims.

Michael S. Wood
Claims Manager
ESIS Fremont WC
P.O. Box 31083
Tampa, FL 33631-3083
Fax: 800-336-0570
tel. (510) 790-8733

PARHAM, WILLIAM N. (CMS/OSORA)

From: Bucksner, Michael [mpbucksner@cvty.com]
Sent: Monday, October 13, 2008 11:50 AM
To: CMS PL110-173SEC111-Comments
Subject: #224 [GHP- registration] MSP Registration for GHP's with Multiple lines of Business

Please advise on how a GHP with multiple lines of business should register. We currently have some lines of business that currently have a VDSA with CMS and other that do not. Also, will this differ with Administration Only clients vs. fully insured clients?

Thanks.

Michael P. Bucksner
Sr. Business Analyst, Strategy and Process
Coventry Health Care
211 Lake Dr.
Newark, DE 19702
(302) 283-6587
mpbucksner@cvty.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Monday, October 13, 2008 11:58 AM
To: CMS PL110-173SEC111-Comments
Subject: #225 [GHP- reporting requirements] Mandatory Reporting for which Group Health Plans?

The most pressing question here is: **For which Group Health Plans must a Reporting Entity provide enrollee information?** The guidance provided at the first Open Door Forum was not entirely clear, and we need such information in writing anyway. For example:

- Health Flexible Spending Account plans?
- Health Reimbursement Account plans?
- Dental-only plans?

In each case, does it matter what types of expenses can be reimbursed by the plan?

If any pre-submitted questions will be answered on 10/22 before the open Q&A begins, an answer to this question is likely to be appreciated by many listeners.

David Pittman
Manager, Compliance | National Support | Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210 | Columbia MD 21044
410-884-1416 (direct) | **410-884-1424** (fax) | **141416** (VOIP)

PARHAM, WILLIAM N. (CMS/OSORA)

From: Upham, William [William.Upham@LibertyMutual.com]
Sent: Monday, October 13, 2008 12:14 PM
To: CMS PL110-173SEC111-Comments
Subject: #226 [NGHP- claims reporting/exposure dates] Sec 111 Mandatory Insurer Reporting Question

During the 10/1/08 teleconference with Liability Insurers, et al the CMS reps discussed exposure/ingestion dates that insurers will be required to submit for pharmaceutical liability claims. However, it was unclear whether this information would be required for asbestos and other toxic tort claims in which the first exposure dates may go back to the early 1940s (occasionally) and routinely extends back to the 1950s and 1960s. The CMS reps mentioned something about pre 1985 dates not being required but it was unclear to me whether that was a general statement or something specific to pharmaceuticals. Could you please clarify under what circumstances CMS will require first exposure dates for non-pharmaceutical latent injury cases?

PARHAM, WILLIAM N. (CMS/OSORA)

From: Gail Powell [gpowell@mcconnaughhay.com]
Sent: Monday, October 13, 2008 12:46 PM
To: CMS PL110-173SEC111-Comments
Subject: #227 [Other- registration fee]

We have two people in our office very interested in attending this. Could you send information regarding registration fee, etc.? Thanks!

McConnaughhay Duffy Coonrod Pope Weaver

Gail Powell, Legal Assistant
McConnaughhay, Duffy, Coonrod, Pope & Weaver, P.A.
1709 Hermitage Boulevard, Suite 200
(32308)
P.O. Drawer 229
Tallahassee FL 32302-0229
gpowell@mcconnaughhay.com www.mcconnaughhay.com
Voice: 850-222-8121 Fax: 850-222-4359

PARHAM, WILLIAM N. (CMS/OSORA)

From: Blair Fowler [bfowler@nwadmin.com]
Sent: Monday, October 13, 2008 1:44 PM
To: CMS PL110-173SEC111-Comments
Subject: #228 [Other- RRE verification] MMSEA 111 reporting

Hello –

How do TPAs verify whether or not we are a current RRE with a VDSA or VDEA?

We do have a current COBA; however, it is unclear if this qualifies as a VDSA or VDEA.

Please advise.

Thank you,

Blair Fowler
Account Executive
Northwest Administrators, Inc.
(206) 926-2694 Direct
(206) 726-3209 Fax
bfowler@nwadmin.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Kristen L. Lawrence [klawrence@marksgray.com]
Sent: Monday, October 13, 2008 1:54 PM
To: CMS PL110-173SEC111-Comments
Subject: #229 [Other- Teleconference registration] How do we register for the call in conference?

Kristen L. Lawrence
Administrative Assistant to
Workers' Compensation Group
MARKS GRAY, P.A.
klawrence@marksgray.com
Telephone (904) 807-2162
Fax (904) 807-2114

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Caldwell [DCaldwell@NJGuaranty.org]
Sent: Monday, October 13, 2008 2:28 PM
To: CMS PL110-173SEC111-Comments
Cc: David Caldwell
Subject: #230 [Other- Confirmation of Medicare beneficiary] What is considered to be appropriate investigation to establish Medicare beneficiaries

What is considered to be an appropriate investigation to establish if a recipient is a Medicare beneficiary?

Would an affidavit signed by the recipient at the time of settlement be sufficient with the necessary information be appropriate?

David Caldwell
Director of Claims
New Jersey Property-Liability Insurance Guaranty Association
222 Mt. Airy Road
Basking Ridge, NJ 07920
(908) 382-7291
www.njguaranty.org

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Caldwell [DCaldwell@NJGuaranty.org]
Sent: Monday, October 13, 2008 2:30 PM
To: CMS PL110-173SEC111-Comments
Cc: David Caldwell
Subject: #231 [Other- Carrier claims reporting] Who are carriers required to report

Carriers will be subject to penalty if we fail to report payments to CMS. Please outline specifically who carriers need to report and under what circumstances.

David Caldwell
Director of Claims
New Jersey Property-Liability Insurance Guaranty Association
222 Mt. Airy Road
Basking Ridge, NJ 07920
(908) 382-7291
www.njguaranty.org

PARHAM, WILLIAM N. (CMS/OSORA)

From: BCurtis@keyrisk.com
Sent: Monday, October 13, 2008 2:34 PM
To: CMS PL110-173SEC111-Comments
Subject: #232 [Other- teleconference registration] Registration for the upcoming teleconference requested

Oct 29 teleconference registration

Barbara Curtis, RN,BSN,CCM,MSCC
Case Manager
800-942-0225 ext. 5027
FAX: 336-605-7580
e-mail :bcurtis@keyrisk.com

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PARHAM, WILLIAM N. (CMS/OSORA)

From: Norman Reese [nreese@LAIGA.ORG]
Sent: Monday, October 13, 2008 3:42 PM
To: CMS PL110-173SEC111-Comments
Subject: #233 [NGHP- reporting requirements] TELEPHONE CONFERENCE OCTOBER 29, 2008

QUESTIONS/

WORKERS COMPENSATION/

CURRENTLY, WHEN WE GET MSA'S IS AT TIME OF SETTLEMENT. WILL REPORTING BE REQUIRED PRIOR TO A SETTLEMENT ?
WHAT ABOUT A CASE THAT NEVER SETTLES. WILL REPORTING BE REQUIRED. ?:"

LIABILITY INJURIES:

WILL REPORTING BE REQUIRED PRIOR TO A SETTLEMENT? WILL ANY CASES BE SUBJECT TO MSA'S AS IN WORKERS COMPENSATION?

Norman L. Reese
Louisiana Insurance Guaranty Association
Director of Claims and Litigation

PARHAM, WILLIAM N. (CMS/OSORA)

From: Joellen David [joellen.david@zurichna.com]
Sent: Monday, October 13, 2008 3:56 PM
To: CMS PL110-173SEC111-Comments
Cc: Maureen Sullivan; Greg Bruning; Joshua Logan
Subject: #234 [Other- data elements] Questions for SCHIP

Hi -

After reviewing the 45 data elements that CMS is requesting from Insurance companies I have some additional questions:

(1) Are all 45 data elements Mandatory, Optional or Situational for all Lines of Business(Worker's Compensation/Liability/No-fault)? Or do they vary by Line of Business?

(2) For #17 & #18 are the Name and Address for the Insured? Employer?

(3) For #16, Insurance type, are codes going to be provided for each Line of Business?

(4) When we are reporting information to CMS, is the information reported only what happened during the reporting period or is it cumulative?(for example #24 Exhaust Information)

Thanks,

Jo Ellen David :+)
Business Process Analyst
Customer Services, Process Improvement
Office: (847) 762-7368

PARHAM, WILLIAM N. (CMS/OSORA)

From: egartman@samhealth.org
Sent: Monday, October 13, 2008 6:52 PM
To: CMS PL110-173SEC111-Comments
Subject: #235 [Other- reporting/ uploading instructions/ assistance] Assistance Requested Questions on Medicare Secondary Reporting Process

Hi,

I went through and reviewed all of the documents which were available on the website and found that there were a few questions that I was not able to have answered. These questions are as follows:

1) What date range of coverage needs to be reported. Is it for any coverage that became or was effective with Medicare on 01/01/09?

2) I understand that you need to apply for a number for each plan, but what are the actual instructions for uploading the required file?

3) Is there a number that we can call for direct assistance if there are any additional questions?

I appreciate your assistance. Please contact me at Egartman@samhealth.org and thanks.

Elizabeth A. Gartman

Operations Manager- TPA Accounts

Samaritan Health Plan Operations

Phone: 541-768-6326

Cell: 541-740-5597

Fax: 541-768-4294

PARHAM, WILLIAM N. (CMS/OSORA)

From: egartman@samhealth.org
Sent: Monday, October 13, 2008 6:52 PM
To: CMS PL110-173SEC111-Comments
Subject: #235 [Other- reporting/ uploading instructions/ assistance] Assistance Requested Questions on Medicare Secondary Reporting Process

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I appreciate your assistance. Please contact me at Egartman@samhealth.org and thanks.

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Phone: 541-768-6326

Cell: 541-740-5597

Fax: 541-768-4294

PARHAM, WILLIAM N. (CMS/OSORA)

From: Cameron, Mike [Mike_Cameron@BCBST.com]
Sent: Tuesday, October 14, 2008 9:52 AM
To: CMS PL110-173SEC111-Comments
Subject: #236 [Other- reporting] Section 111 Question

Regarding the new quarterly file process, if someone is sent on the file and is not a "hit" with CMS, it is my understanding that we send them again the next quarter as an add record.

Is this correct?

Thanks.

Mike Cameron
Litigation Project Manager
Legal
Phone: (423) 535-6361
Fax: (423) 535- 1984
Cell: (423) 667-3406

PARHAM, WILLIAM N. (CMS/OSORA)

From: Decker, William F. (CMS/OFM)
Sent: Tuesday, October 14, 2008 9:57 AM
To: CMS PL110-173SEC111-Comments
Subject: #237 [Other- PBMs and reporting requirements] FW: MSP Reporting

Bill Decker
CMS
410-786-0125

From: Colcord, Lois [mailto:Lois.Colcord@caremark.com]
Sent: Monday, October 13, 2008 9:30 AM
To: Decker, William F. (CMS/OFM)
Subject: MSP Reporting

We have a few questions we would like you to pose to CMS regarding the new mandatory reporting requirements applicable to group health plans (GHPs). These requirements are contained in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA and are effective 1/1/09. CMS provides information about the mandatory reporting requirements at https://www.cms.hhs.gov/MandatoryInsRep/

Bill,
We are particularly interested in learning whether PBMs are viewed by CMS as subject to these requirements (i.e. whether PBMs are a "responsible reporting entity" or RRE) in any circumstances. As background, CMS states that third party administrators (TPA's) that adjudicate claims for a GHP are RRE's, but CMS also makes clear in its operational documents (specifically, the CMS "Supporting Statement") that reporting of drug coverage (as opposed to medical coverage) is for now optional.

In light of the above, our questions are as follows:
Question: 1
Can CMS confirm that PBMs that provide traditional PBM services (i.e. adjudicating drug claims) are not considered to be "third party administrators" and therefore not a Responsible Reporting Entities (RREs) under Section 111?

Question 2
Please confirm that this is the case even if a GHP chooses the Expanded Reporting option (which includes drug coverage).

Question 3
In the case of a GHP that has chosen the Expanded Reporting option level, is it required to report all of the pharmacy data elements listed in Attachment C of the Supporting Statement (i.e. data elements #24-29)? It is not clear, because of variations in instructions for input file data field listed below (taken from the CMS document entitled "Transitioning Into Section 111 Reporting, p.31)

Rx Insured ID number Insured's Identification Number for prescription drug coverage.
Applies to drug coverage information reported when using the Expanded Reporting Option.
Required for coverage types U, W, X, & Y
Rx Group Number Group Number for prescription drug coverage.
Applies to drug coverage information reported when using the Expanded Reporting Option.
For use when coverage type is V, Z, 4, 5, and 6.
Rx PCN Rx Processor Control Number.
Applies to drug coverage information reported when using the Expanded Reporting Option.
Required if available.

Rx BIN Number Benefit Identification Number for Rx processing.
Applies to drug coverage information reported when using the Expanded Reporting Option.
Required for coverage types U, W, X, & Y
Rx Toll Free Number Prescription Drug/Pharmacy Benefit Information Toll Free Number.
Applies to drug coverage information reported when using

Thanks
Lois Colcord, RPh, MBA
Director, Medicare Program Services
CVS Caremark
ph 480-661-2383 ; fax 480-661-4621
Lois.Colcord@Caremark.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: alockridge@cameron-insurance.com
Sent: Tuesday, October 14, 2008 12:01 PM
To: CMS PL110-173SEC111-Comments
Subject: #238 [NGHP- reporting requirements] Comment

To Whom It May Concern:

My name is Andrea Lockridge. I am the General Counsel and Assistant Secretary of Cameron Mutual Insurance Company located in Cameron, Missouri. Cameron Mutual is a small to mid-sized property and casualty insurer writing various P&C products in Arkansas, Missouri and Iowa. As Cameron Mutual and its sister company, Cameron National Insurance Company, each write liability insurance, the proposed data collection regulations will affect both Cameron Mutual and Cameron National. Please allow me to submit the following comment on behalf of each company:

We have reviewed the materials put out by the Centers for Medicare & Medicaid Services and have evaluated the impact upon our business. Although we collect much of the information which will be required to be submitted, there are several categories of information that we are not currently capturing in our systems. We would suggest that the proposed categories of information which will be required to be submitted are too broad. We request the required information be narrowed down to only those categories of information absolutely necessary to allow Medicare/Medicaid to maintain its secondary payor status. We believe that Medicare/Medicaid should be able to accomplish this with the name, date of birth, SSN and date of the incident causing the injury to the person claiming Medicare/Medicaid benefits.

Furthermore, we believe the penalty provisions in the regulations should include some type of safe harbor for those claims in which the claimant (who is not required to cooperate with the insurer) refuses to supply the requested information, but the insurer has made a good faith effort to obtain such information. We do not have judicial or governmental authority to require that information be provided to us, nor do we have the power to enforce any regulations that require such claimants to cooperate in coordinating Medicare/Medicaid benefits. This should be recognized and accounted for in the regulations.

For a small company such as ours, compliance with this mandate will be very burdensome. Implementing the systems necessary to comply with this mandate will require a substantial diversion of resources which are integral to the day-to-day operation of our business. This diversion of resources will derail the timely progress of several projects which have been in the works for months. It will also hamper our ability to commence new projects designed to enhance our insurance offerings for our customers. By reducing the amount of information required to be submitted, you will reduce the impact upon the operations of each entity required to comply.

Additionally, we would like to inquire as to whether the Centers for Medicare & Medicaid Services have a process in place to independently request that the medical service providers obtain information on primary payors from their patients. It would not be out of line to ask the patient if there is a liability insurance company or other entity that would be responsible for the medical bills before Medicaid/Medicare actually disburses payment. Placing the information collection burden solely on the primary payors is solving only half of the problem. We should also hold Medicare beneficiaries accountable to Medicare/Medicaid to ensure the proper party is paying the bill.

Thank you for your thoughtful consideration of this matter.

Sincerely,

Andrea L. Lockridge
General Counsel and Assistant Secretary
Cameron Mutual Insurance Company
214 McElwain Dr.
Cameron, Missouri 64429
816-632-6511 ext. 351

COMMENT ON SENATE BILL 2499/42 USC 1395(y)(b)(8)

There appears to be a conflict concerning exactly when the obligation to provide requested information to Medicare begins. The new law provides that, "[o]n and after" July 1, 2009,

"an applicable plan shall-
(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title... on any basis; and
(ii) if the claimant is determined to be so entitled, submit the information described in sub paragraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

42 USC 1395y(b)(8)(a)(emphasis added).

Shortly after this wording, however, the law indicates that the requested information must be provided to Medicare "within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability)." 42 USC 1395y (b)(8)(c)(emphasis added).

Therefore, it is not clear if the obligation to determine the status of the claimant and provide notification to Medicare exists for claimants who truly have unresolved claims or whether the obligation to notify Medicare begins after the claim is resolved. **Please clarify whether the obligation to notify Medicare of a claim with a Medicare beneficiary exists for all unresolved claims or only after such claims are resolved.**

It would seem very important that the timing of the duty to report a claim to Medicare be very clear as the penalties for non-compliance are rather significant.

Submitted on September 3rd, 2008 by:

Melisa C. Zwilling, Esq.
Carr Allison
100 Vestavia Parkway
Birmingham, Alabama 35216
Direct Dial: (205) 949-2949
Email: mzwilling@carrallison.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Bill Ashley [bashley@alliednational.com]
Sent: Monday, September 08, 2008 7:52 PM
To: CMS PL110-173SEC111-Comments
Subject: #10 [misc. GHP] Reporting Requirement Comments

Reviewing all information I could find there is a shortage of information being provided, especially some key definitions. We will be reporting as a GHP.

1) Is reporting only on members where we believe Medicare is primary? If we're already paying as secondary do we report this member?

2) When insuring multiple related legal entities insured under a single contract, which EIN should be reported? We currently do not collect or store the employer EIN as it is not relevant to the processing of fully insured benefits. The necessity for special programming to capture this data was not recognized in the calculation of "burden" nor does sufficient time exist prior to the January 1st dead-line for programming to allow the capture of this data item.

3) We store the SSN of the policyholder, not insured dependents. We have no system provision to store SSN on dependents. The necessity for special programming to capture this data was not recognized in the calculation of "burden" nor does sufficient time exist prior to the January 1st dead-line for programming to allow the capture of this data item.

4) Given that it is a moving target, how is the GHP supposed to determine the size of the employer (referenced data element). What is meant by the size of the employer? Number of employees? The necessity for special programming to capture this data was not recognized in the calculation of "burden" nor does sufficient time exist prior to the January 1st dead-line for programming to allow the capture of this data item.

5) Attachment C - GHP Data Elements in the recent reporting statement seems to be the only document hinting at reporting requirements. Since no file layout information has been published (that we can find), what is the date when this information is going to be available? The necessity for special programming to comply was not recognized in the calculation of "burden" nor does sufficient time exist prior to the January 1st dead-line for programming to allow the development of special reporting programming.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Tuesday, September 09, 2008 9:34 AM
To: CMS PL110-173SEC111-Comments
Subject: #12 [GHP definition of insurer] GHP data elements - Insurer

Sir/Madam:

We are a TPA administering self-funded group health plans. We need to understand the term **Insurer** and how this would be interpreted to apply to our self-funded client group health plans.

Thank you.

Ann Poland
Director of Legislative Research
CoreSource, Inc.
9775 Crosspoint Boulevard, Suite 118
800-345-0555 ext 13
Fax: 317-578-3543
apoland@coresource.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Tuesday, September 09, 2008 9:36 AM
To: CMS PL110-173SEC111-Comments
Subject: #13 [GHP definitiion of ER size] GHP data elements - Employer Size

Sir/Madam:

We are a TPA administering self-funded group health plans. We need to understand the element **Employer Size** and how this would be interpreted to apply to our self-funded client group health plans. Is the intent that this is total employee count of the employer or total employee participants in the GHP?

Thank you.

Ann Poland
Director of Legislative Research
CoreSource, Inc.
9775 Crosspoint Boulevard, Suite 118
800-345-0555 ext 13
Fax: 317-578-3543
apoland@coresource.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Tuesday, September 09, 2008 9:38 AM
To: CMS PL110-173SEC111-Comments
Subject: #14 [GHP definition DCN] GHP Data Elements - Document Control Number

Sir/Madam:

We are a TPA administering self-funded group health plans. We need to understand what the **Document Control Number** is to represent. Would this number be the same for all record sent by us as the TPA for our GHP clients?

Thank you.

Ann Poland
Director of Legislative Research
CoreSource, Inc.
9775 Crosspoint Boulevard, Suite 118
800-345-0555 ext 13
Fax: 317-578-3543
apoland@coresource.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Tuesday, September 09, 2008 9:40 AM
To: CMS PL110-173SEC111-Comments
Subject: #15 [GHP transaction type] GHP Data Elements - Transaction Type

Sir/Madam:

We are a TPA administering self-funded group health plans. Would **Transaction Type** be blank if there was no change to the record being provided (ie no change in participant status from one quarter to the next) or are we only to submit data that represents a change?

Thank you.

Ann Poland
Director of Legislative Research
CoreSource, Inc.
9775 Crosspoint Boulevard, Suite 118
800-345-0555 ext 13
Fax: 317-578-3543
apoland@coresource.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Tuesday, September 09, 2008 4:34 PM
To: CMS PL110-173SEC111-Comments
Subject: #17 [GHP is FSA + GHP & other] Mandatory Reporting: Health FSAs

The law specifies that every group health plan (or its TPA or insurer) must obtain and submit information required by the Secretary. However, first the Secretary must determine what information is required, which includes determining which health plans must provide information. Health FSAs are group health plans for other purposes, but previous guidance has indicated that Health FSAs are not group health plans for Medicare Secondary Payer purposes:

> **"Flexible Savings Accounts (FSA), Health Savings Accounts (HSAs), Archer Medicare Savings Accounts (MSA)**
> "For MSP purposes, FSAs, HSAs, and MSAs are not group health plans and thus are not subject to being a primary payer under MSP laws."
> http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CobGuidance_07.01.05.pdf

Future guidance regarding Mandatory Reporting should specify whether or not information will be required from Health FSAs.

Please note that Health FSA administrators typically do not maintain enrollment information regarding dependents whose medical expenses may be reimbursed. Only the employee enrolls in the plan.

David Pittman
Manager, Compliance | National Support | Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210 | Columbia MD 21044
410-884-1416 (direct) | **410-884-1424** (fax)

PARHAM, WILLIAM N. (CMS/OSORA)

From: David Pittman [dpittman@zenithadmin.com]
Sent: Tuesday, September 09, 2008 4:55 PM
To: CMS PL110-173SEC111-Comments
Subject: #19 [GHP age threshhold; HIPPA "minimum necessary"] Mandatory Reporting: Which individuals? (HIPAA: Minimum Necessary)

The law specifies that group health plans (or their TPA or insurer) must obtain and submit information required by the Secretary. However, first the Secretary must determine what information is required, which includes determining which individuals must be reported. The Implementation Guide for the VDSA program addresses essentially the same issue:

> "At a **minimum**, we require the partner to include information about all Active Covered Individuals who are at least 55 years of age, and older. We have found that about ninety-seven percent of all Medicare beneficiaries are 55 and above."
> http://www.cms.hhs.gov/InsurerServices/Downloads/vdsauserguide.pdf

Future guidance regarding Mandatory Reporting should specify the categories of individuals whose information will be required.

Please note that CMS and group health plans are subject to the Privacy Rule's "Minimum Necessary" standards:

> 164.502 **Uses and disclosures of PHI: General rules**.
> (b) Standard: Minimum Necessary.
> (1) Minimum Necessary applies. When using or disclosing PHI or when requesting PHI from another covered entity, a covered entity must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

The VDSA guide could be interpreted as stating that Medicare's minimum necessary requirements are that partners must report Active employees and their dependents who are age 55 and older. Future guidance regarding Mandatory Reporting should not only state what is required, but also explain how the requirement is consistent with the Minimum Necessary Standard and Implementation Specifications. And if the Mandatory Reporting requirement is different from the VDSA requirement quoted above, the difference should be explained in the context of Minimum Necessary: why is the Minimum Necessary for Mandatory Reporting different from the Minimum Necessary for Voluntary Data Sharing?

David Pittman
Manager, Compliance | National Support | Zenith Administrators, Inc.
5565 Sterrett Place, Suite 210 | Columbia MD 21044
410-884-1416 (direct) | **410-884-1424** (fax)

PARHAM, WILLIAM N. (CMS/OSORA)

From: Robert_Kasischke@gbtpa.com
Sent: Wednesday, September 10, 2008 2:30 PM
To: CMS PL110-173SEC111-Comments
Subject: #20[NGHP(?): lack instructions. object electronic only, reportable events, correction process] General comments

I've spent the last 3 days reviewing the information on your website.

Major concerns:
1) For an entity that expects the business community to implement something by **June** 1, 2009, there is still a large amount of information missing (exactly WHAT are you looking for?, Timelines, testing procedures, record layout's and User Guides for instance). There is insufficient information for me to determine what I need to do to comply. (In effect you've said "JUMP" but you have yet to say how high).

2) The website _seems_ to imply that only a web based interface will be the principal method of supplying information. This approach may work for small companies with a small population. This is not workable solution for larger entities. Especially the initial claim load.

3) While you have stated you are looking for certain data elements regarding claims. What you have failed to describe is exactly which claims you are interested in. Active claims only? Inactive claims? Claims settled in the last 5, 10 years? What is the definition of a " Medicare beneficiary"? We currently have no way to determine if a claimant is disabled (and therefore eligible for Medicare) Will CMS be providing us with a list of Medicare beneficiaries?

4) Correction process: how do we correct claim information?

Thanks

Bob Kasischke
Business Systems Consultant
Gallagher Bassett Services, Inc. - Itasca, IL.
630-285-3729

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 9:26 AM
To: CMS PL110-173SEC111-Comments
Subject: #21b [file layout-inquiry is NGHP but Q could apply to GHP as well] Non-MSP VDSA Layout

Should an insurer base their file layouts on the current VDSA, but include the fields defined in the CMS Supporting Statement?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 9:28 AM
To: CMS PL110-173SEC111-Comments
Subject: #23 [response file issue] Non-MSP Web Submissions

If an insurer is reporting to CMS through the website, will CMS provide corrected information to the insurer if CMS information differs from that of the insurer? How will this information be provided to the insurer?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 9:28 AM
To: CMS PL110-173SEC111-Comments
Subject: #24 [NGHP -- update & frequency Q] Resubmission of Data

When should an insurer send claim/claimant updates to CMS? Are updates due whenever there is a payment or when the insurer identifies claimant demographic, i.e. address info, has changed? Is this information supposed be submitted quarterly?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:29 AM
To: CMS PL110-173SEC111-Comments
Subject: #25 [NGHP --ability to write a secondary policy?] Non-GHP Supplemental Policies

What if an insurer writes Liability, Self-Insured, or Workers' Comp policies that are supplemental policies to Medicare/Medicaid? By definition, the insurer is the secondary payer for these policies.

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:32 AM
To: CMS PL110-173SEC111-Comments
Subject: #28 [NGHP -- frequency] Non-Contested Report Frequency

The frequency requirement states: collection will be no more than a quarterly basis…ongoing basis for no-fault/WC non-contested claims – are these reports supposed to be ongoing reports for the life of the claim but only submitted per quarter or are these reports supposed to occur more frequently during the life of a claim.

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:33 AM
To: CMS PL110-173SEC111-Comments
Subject: #31a [NGHP -- beneficiary relationship Q] Parent Relationship Type

Why is "Parent" not a valid type for beneficiary relationship?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:34 AM
To: CMS PL110-173SEC111-Comments
Subject: #31b [NGHP] Insurer Plan Additional Info

An "Additional Information" field exists for the Primary Plan, what is this field used for, what are the maximums, and is this related to the claim, policy, claimant or some other information?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sargent, Shannon [Shannon.Sargent@StateAuto.com]
Sent: Friday, September 12, 2008 10:34 AM
To: CMS PL110-173SEC111-Comments
Subject: #32 [NGHP -- exhaust info field] No-Fault Exhaust Info

Is the "Exhaust Information" a date field or monetary amount?

Shannon Sargent
Business Analyst
State Auto Insurance Companies www.stateauto.com
PO Box 182822, Columbus, OH 43218-2822
Phone: 614.917.5245 Fax: 614.887.1564