America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

September 29, 2008

CMS
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number--CMS 10265/OMB# 0938—New
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

RE: CMS--10265 [OMB# 0938--New]

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice published on August 1, 2008 by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register (73 FR 45013) under the Paperwork Reduction Act of 1995 (PRA) on "Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173)." AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. The reporting requirements are of significant interest to AHIP's member organizations, many of which will be subject to the requirements described in this notice, the accompanying PRA documentation and subsequent publications appearing on the CMS Mandatory Insurer Reporting Website at www.cms.hhs.gov/MandatoryInsRep. AHIP's detailed comments on these documents appear below.

GENERAL COMMENTS

- **Resolution of Data Discrepancies.** It is unclear from the Supporting Statement or documentation on the Mandatory Insurer Reporting (MIR) website how CMS and Responsible Reporting Entities (RREs) will resolve discrepancies between data obtained and reported by RREs on the GHP MSP Input File and data reported by the COBC on the GHP MSP Response File. For example, if the information the beneficiary provided to the RRE conflicts with data from the COBC, it is unclear which information will take precedence, how data will be reconciled and corrected, and under what timeframe CMS will require corrections be made. AHIP recommends that CMS provide instructions on how variation between RRE and COBC data will be reconciled including what evidence is required to document the RREs record, how the RRE obtains authorization to change the record in the file, and the timeframe under which reconciliation should occur when information the beneficiary provides to the RRE conflicts with the COBC data.

- **Medicare Advantage Organizations.** Medicare Advantage Organizations (MAOs) are required to report MSP information on their enrollees to CMS for purposes of payment adjustment. Some Medicare beneficiaries who are actively working have elected to purchase coverage under their employer's plan and in addition, enroll in an MA plan. In the event the employer group plan and the MA plan are offered by the same organization, this would result in duplicative reporting. In order to avoid duplicative reporting, AHIP recommends that CMS specify in the Supporting Statement that if a health insurer has, in its capacity as an MA plan, reported MSP data for its MA enrollees to CMS for purposes of payment adjustment in the format required under Mandatory Insurer Reporting (MIR), the insurer will not be required to additionally report these same data on the same individuals to CMS in their role as a RRE. We further recommend that CMS provide guidance on how data will be reconciled in the event the RRE and the MA plan are different reporting entities and the information they report differs.

- **Provision of Primary Insurer Information to MAOs and Cost Plans.** MAOs and cost plans are required to comply with the MSP statute and pay secondary when another insurer (including a group health plan, liability, no fault, or workers' compensation insurer) is determined to be primary under applicable MSP rules. MMSEA permits CMS to share MSP data for purposes of proper coordination of benefits. Therefore, to achieve the full savings that Congress intended, AHIP recommends that CMS make available to MAOs and cost plans information on MSP coverage enrollees in these plans have which the agency obtains through the MIR program.

- **Penalties.** Under the statute, RREs are subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which information should have been submitted. In addition, an employer is subject to a civil monetary penalty not to exceed $1,000 for each individual when the employer willfully or repeatedly fails to provide timely and accurate determinations to the carrier or intermediary. In the event that an RRE has done due diligence and made a good faith effort to obtain information and an employer or employee has failed to provide information, it is not clear, whether the RRE would be subject to a civil monetary penalty. AHIP recommends that CMS clarify under what situations a penalty may be imposed on an RRE. We further recommend that when an RRE has attempted, but failed to obtain information from an employer or insured that the RRE not be subject to the civil monetary penalty.

- **Treatment of COBRA Enrollees.** Guidance issued on September 25, 2008, entitled "Group Health Plan (GHP) Data Elements: Who Must Be Reported?" lists the individuals who should be included in the data reported by RREs. The list refers to "active covered individuals" as having coverage based on their own or a family member's "current employment status." Section 20 of Chapter 1 of the Medicare

Secondary Payer Manual clarifies that COBRA coverage is considered secondary for enrollees who are Medicare eligible due to age or disability. Section 20 further clarifies that COBRA coverage is primary to Medicare during the 30 month ESRD-coordination period for enrollees with ESRD. AHIP therefore recommends that CMS clarify that GHPs need not report on individuals who maintain COBRA coverage and are Medicare eligible by virtue of age, disability, or having passed through the 30-month ESRD coordination period.

SPECIFIC COMMENTS

Supporting Statement

Attachment B

- **The Need for Social Security Numbers and/or Health Insurance Claim Numbers.** It has been the experience of AHIP member organizations that some enrollees are reluctant or unwilling to share their Social Security Number (SSN) and/or Health Insurance Claim Number (HICN). Likewise, some employers are reluctant to release their Employer Identification Number (EIN) or to obtain SSNs for spouses and dependents covered under an employee's policy. For that reason we express our thanks to CMS for releasing the June 23, 2008 Alert, that provides RREs with information that can be used to advise individuals that collection of SSNs, HICNs, or EINs for purpose of compliance with the reporting requirements is appropriate. We further appreciate CMS' September 25, 2008 document, entitled "Group Health Plan (GHP) Data Elements: Who Must Be Reported?" wherein the agency clarifies that RREs do not have to report SSNs for spouses and other family members covered under an individual's policy until the first file submission in the first quarter of 2010, when the initial coverage date for such individuals was prior to January 1, 2009. We would note that this later clarification is to be included in the User Guide for entities that do not now have a VDSA/VDEA with CMS and recommend that it also be included in the Guide for those entities that *do* currently have such an agreement.

  Even with these provisions, AHIP members are concerned that it will not be possible to obtain SSNs, HICNs, or EINs from all individuals for whom they are required to report MSP data. AHIP recommends that as noted in our comments above under "Penalties," CMS stipulate that when plans have made an appropriate good faith effort to obtain these numbers and have been unable to do so, they not be subjected to a penalty.

  In addition, we note that in the Justification provided with the Supporting Statement, the fourth point notes that successful implementation of MSP reporting "will allow CMS to eliminate or curtail other Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match." If employers were aware of the possibility that

their burden in regard to IRS/SSA/CMS data matching could be diminished, employers might be more willing to collect and share SSNs, HICNs, and EINs. We therefore recommend that CMS provide a document that GHPs can use with their employer customers to demonstrate this potential benefit of the program.

Implementation Timeline

- **Compliance Timeframe.** As a result of the MIR program, RREs will need to reallocate or obtain new resources to achieve compliance including re-contracting with numerous employer groups, obtaining significant amounts of data from their enrollees and employers, and implementing and testing systems. To ensure that RREs will be able to meet their obligations under the statute, AHIP recommends that CMS extend the timeline for testing and submitting production files.

- **When Not All Lines of Business are Currently Reported through a VDSA/VDEA.** Some RREs may voluntarily report information on individuals associated with specific employer groups under an existing VDSA/VDEA, but not report data through the VDSA/VDEA process on all groups they insure. To begin reporting on the additional employer groups, the RRE may need to renegotiate contracts with the employer and obtain all data on the employee or family member to complete the reporting requirements, just as an RRE new to the process would need to do. AHIP recommends that CMS provide RREs in this situation with the option of reporting only their currently reported groups under the process provided for those RREs with an existing VDSA/VDEA, and to begin reporting for new groups under the timeline established for new GHP RREs.

Transitioning Into Section 111 Reporting

- **Age Threshold**. CMS indicates on page 3 of the Transitioning document that Responsible Reporting Entities (RREs) must report on individuals "not otherwise known to be Medicare beneficiaries" who are 45 years of age and older. As noted by CMS, the existing VDSA/VDEA programs require reporting for those aged 55 and older. Decreasing the age will result in a significant burden on RREs due to the increased data collection and reporting demands, while it is unlikely that that individuals who are thus newly reported will make a significant difference in terms of data that can be utilized by CMS to affect payments. AHIP therefore recommends that CMS retain the current age 55 threshold in the MIR program.

- **Use of Pseudo-TINs.** On page 3 of the Transitioning document, CMS indicates that the use of pseudo-TINs will no longer be permitted. Because there may be a lag between when

reporting begins and when plans are able to obtain TINs, AHIP recommends that CMS allow for a transition period during which pseudo-TINs may continue to be used.

- **Basic and Expanded Reporting.** In this document plans are provided with the option of either basic or expanded reporting. It is unclear whether a plan could begin with basic reporting and then move to expanded, or visa versa. AHIP recommends that CMS allow plans that option and specify how frequently a change could be made.

- **TIN of Insurer/TPA.** Field 8 of the GHP MSP TIN Reference File Detail Record (p. 14) refers to a TIN indicator described as E for employer TIN and I for Insurer/TPA TIN. However, Fields 21 and 22 on page 10 of in the GHP MSP Input File Detail Record refers only to Employer and Insurer TINs. It is not clear where a TPA TIN would be entered in the GHP MSP Input File Detail Record. AHIP recommends the GHP MSP Input File Detail Record specifically indicate where the TPA TIN should be entered.

- **Employee Status.** Field 20 of the GHP MSP Input File Detail Record describes the "2" value as indicating that the plan is primary for another reason than that the employee is an active worker, and gives ESRD as a justification for such situation. It is unclear whether the "2" value is meant to be used only in cases of ESRD, or if there may be other possibilities for its use. AHIP recommends that CMS provide clarity on this point.

- **Late Submission Indicator.** Field 82, Late Submission Indicator" in the GHP MSP Response File Detail Record notes that this field will indicate whether the submitted record was not received on schedule. It is unclear what CMS intends to do with the information in this field. AHIP recommends that CMS clarify the use of Field 82.

We have appreciated the opportunity to comment. Please contact me if additional information would be helpful or if you have questions about the issues we have raised. I can be reached at (202) 778-3295 or srohan@ahip.org.

Sincerely,

Sue Rohan

Sue Rohan
Vice President, Federal Program

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Claimant Entitlement to Medicare
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Claimant Entitlement to Medicare

- Does entitled to benefits under Medicare in the context of non-GHP mean only those claimants actually enrolled in Medicare? If not, how does CMS define entitled? How are non-GHP reporters to determine entitlement if it means something other than enrollment?

- Is this determination to be made on the basis of the claimant's entitlement to Medicare on the date the claim is filed with the non-GHP payer? Other? If so, when?

- Does CMS view 42CFR411.25 to be in conflict with the section 111 requirements?

- If the claimant is an illegal alien, must we report?

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Reporting of Claims
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Reporting of Claims

- Does section 111 apply only to claims filed after July 1, 2009; dates of injury after July 1, 2009; or does it include claims where any payment is made after July 1, 2009? What if a full and final settlement is agreed to prior to July 1, 2009, but payment either in a lump sum or through a structured settlement is not completed until after July 1, 2009?

- If the determining factor is date of payment, is this limited to payment for medical treatment and to payment of past or future medical expense?

- Is CMS considering some *de minimus* limit on the size of the medical component of claims that require reporting? There are a large number of non-GHP claims that involve only first aid treatment or "medical only" payments under $500.

- If a non-GHP insurer believes that it is more cost effective for it to report all of its claims and let CMS sort out the ones it wishes to investigate, will CMS accept such reporting?

- If the non-GHP payer is either very small or its claims volume is very small because the coverage it writes involves only a very limited amount of medical coverage, is any consideration being given to set a *de minimus* limit on the claims volume subject to the section 111 reporting requirements?

- Is CMS aware, and how does it plan to address, the differences in the type of deductibles available in the non-GHP environment? Claims under a deductible may be administered by the insurer and be reimbursed by the policyholder. Claims within the deductible may be paid by the policyholder and administered by the policyholder or by a TPA selected by the policyholder. The policyholder may be fully insured but may administer the claim. Some policyholders may pay small claims falling within the deductible and never report them to the insurer.

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Timing of Reporting
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Timing of Reporting

- There is some confusion regarding the timing of the reporting. Collection frequency is stated as being no more than quarterly. Yet the same paragraph provides that "Non-GHP data will be on an ongoing basis for non-contested claims and on a one-time basis for contested cases where there is a single settlement, judgment, award, or other payment." Does this mean that in a non-contested claim where medical bills are sent in roughly every two weeks, that the reporting requirement is that we report the aggregate amount paid at the end of each reporting quarter or do we report the bills paid individually at the end of the calendar quarter? How are contested cases to be reported that aren't resolved but for which multiple payments are made. Are awards and settlements to be reported on a one-time basis even if they involve multiple payments (for example, a workers compensation open award ordering payment until further orders or a structured settlement)?

- What if during a reporting quarter there are indemnity benefits paid but no medical paid, must a report be filed?

- What if a settlement resolves only part of future liability and leaves open other parts? What if the part remaining open does not involve medical?

- Is the date triggering the reporting of a settlement, judgment, or award the date it was signed or entered or the date when payment is actually made?

- A few states require insurers to commence payment of medical up to a certain amount while they are still within the period for investigating a claim. Others require payment of benefits during the pendency of an appeal and may or may not provide some method of reimbursement from other than the claimant if the carrier prevails. Do these payments have to be reported?

- If there are multiple insurers that insure layers of coverage ($0-$100,000, $100,000-$300,000, $300,000-$1 million, etc.), is the individual insurer's obligations to report triggered only when their layer is reached?
- Who reports what and when, when joint or joint and several liability is involved?

Document Identifier: CMS -10265
Questions on Section 111 for CMS Determination

Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Determination

- Despite the fact that Medicare is in the best position to determine whether or not an individual is "Medicare entitled," the burden is placed on the non-GHP payer. Will CMS establish an on-line data base that we can query to determine the claimant's Medicare status? Other federal agencies have done so such as the Treasury's Office of Foreign Assets Control's Specially Designated Nationals List.

- CMS has said that it might develop a form that could be given to the claimant or attorney asking about the claimant's Medicare status. Is this being done? If so, will we have met our obligation to determine the claimant's Medicare entitlement if the form is filled out? What if the claimant is not the person injured? Can CMS provide us with authority to require that the claimant fill out the form?

- In many cases, the non-GHP payer, especially liability payers, will have neither the Medicare Health Insurance Claim Number nor the claimant's Social Security Number. Moreover, they have no leverage to force the claimant to provide the information. Most of these claims are resolved without litigation and so there is no mechanism to compel the claimant to disclose either number. Also, we have no contractual relationship with the claimant and their position is antagonistic to that of our policyholder. How does CMS expect that non-GHP payers are to obtain this information?

- If non-GHP payers make good faith efforts but cannot obtain the number or are given an incorrect number and file a report without it, will CMS accept it? Will the payer be subject to penalty?

- What written assurance can CMS provide to insurers that they will not be prosecuted for violating state unfair claims settlement practices act or state or federal privacy requirements?

- If CMS prepared to enter into hold harmless agreements with data providers against criminal or civil penalties imposed for demanding Social Security Numbers?

- What if the claimant has no Social Security Number? Depending on your definition of Medicare entitled, are there "Medicare entitled" claimants that may not have HICNs?

- While rare, there are cases in which insurers provide coverage to federal contractors and for national security reasons are asked to pay claims without knowing the identity of the claimant. How does CMS propose handling such cases?

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Records Retention
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Records Retention

- Why is CMS recommending a ten year records retention period for MSP related information?
- How does "Absence of related information does not constitute a valid defense against an MSP recovery action" relate to a reporting obligation?
- What is the "administrative offset" and how does it relate to non-GHP payers?
- Is CMS suggesting that the False Claim Act applies in the Medicare Secondary Payer setting despite several court rulings that it does not?

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Reporting Process Questions
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Reporting Process Questions

- If a non-GHP payer is an insurance group and it has a number of companies, markets and divisions with multiple data systems that will be reporting to CMS, does CMS have preference as to whether the group registers as single responsible reporting entity or whether each unit that will be reporting using its own data system registers as a responsible reporting entity?

- In the quarterly reporting, will there be batch reporting and can reports of settlements, judgments, and awards be reported along with reports of payments in non-contested cases?

- Will responsible reporting entities receive acknowledgements from CMS that their data was received?

- In addition to electronic reporting, will CMS provide a website portal for non-GHP entities to report if their claim volume is so low that electronic data transmission would not be cost effective?

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Data Related Questions
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Data Related Questions

- In the last paragraph on page 9 of the supporting statement, a reference is made "see Attachment C – Non-GHP" shouldn't that be Attachment D?

- Does CMS appreciate that not every data element will necessarily be in an electronic claim file and that the information may not all be in a single data base? CMS' cost estimate does not seem to be aware of that.

- Why should it be our responsibility to provide the claimant's e-mail even if we have it? The data elements should be limited to those to put CMS on notice. "Nice to have" fields add to expense of reporting for both the rre and CMS with limited benefits.

- Will there be an unknown code for gender?

- What relevance do data elements 12-15 have to CMS if medical costs aren't being claimed?

- Why does CMS need the name of the policyholder if the policyholder is not the injured person and may not have been involved in the accident?

- Is CMS aware that no-fault and liability policies may have multiple coverage limits?

- Is it CMS' intent to collect exhaust information only for medical benefits?

- Does CMS recognize that in workers compensation (and other lines) that date of first exposure may not be necessary information? Occupational disease provisions base benefit entitlement on date of disability, date of last exposure, or date of last injurious exposure.

- Please explain what are the WCIO tables and why are you proposing to use them?

- Is CMS planning on providing a significant lead time for rre's to change systems when CMS moves to the ICD-10 Codes?

- How does CMS define "state of venue"?

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Data Related Questions
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

- Is data element #40 asking whether this claim is a product liability claim or whether there is any product liability claim involved?

- Why is CMS requesting #41?

- How does CMS define a "contested claim" and "on-going responsibility"? Will code values be assigned to the listed options?

- Explain why item #45 is situational and define "recovery claim" (i.e., for conditional payments?)

- As was pointed out previously, the mandatory data element that will be most difficult to provide is the SSN or HICN. Will there be a code for "refused" if the claimant will not provide it to the non-GHP payer?

- Please clarify your meaning of "injured party," "claimant" and "beneficiary." If by "injured party" you mean the person(s) who was physically or emotionally injured, please make that clear. From a single accident, there could be claims by the person physically injured, family members, the estate and even by-standers. Your definitions should be limited to those seeing reimbursement of or damages for medical treatment costs.

Document Identifier: CMS -10265
Questions on Section 111 for CMS
Other Questions
Submitted By: Keith Bateman, Property Casualty Insurers Association
Contact Information: 847-553-3802, keith.bateman@pciaa.net

Other Questions

- Has CMS added additional staff to assure CMS will be able to receive and acknowledge receipt of data in a timely fashion? Has staff been added to respond to payer inquiries about Medicare eligibility and outstanding Medicare liens?

- Does complying with the mandatory reporting requirements and satisfying any outstanding Medicare liens at the time of settlement satisfy the insurer's obligations as a MSP?

- Is there an appeal process for challenging the imposition of fines for failure to timely report to CMS?

- Does CMS believe its definition of insurer includes any residual market mechanism, guaranty fund, state uninsured employer fund, etc., that is making claim payments?

- Must insurers report on payments made after July 1, 2009 on claims where the date of injury is prior to enactment of the applicable Medicare Secondary Payer requirement?

PARHAM, WILLIAM N. (CMS/OSORA)

From: Hale, Jonathan [JHALE@hne.com]
Sent: Monday, September 29, 2008 5:20 PM
To: CMS PL110-173SEC111-Comments
Subject: #127 [SSN collection] Questions for Open Door Forum Teleconference October 1, 2008

Hi,

As a Commercial Managed Care Organization we've always had a good reason to collect employee Social Security Numbers from Employers as that is an identifier that we can use to connect the Employer's Human Resource and/or Payroll system to our Enrollment, Billing and Accounts Receivable system. We've never had a good reason to collect spouse and dependent Social Security Numbers from Employers as there was no business use for the information.

1) Is it the intent of MMSEA 111 for health plans to start collecting more Social Security Numbers, especially for Spouse and Dependents?

2) Is there any sanction to Employers, Employees, Spouses or Dependents that do not share the Social Security Number with the Health Plan?

The original HIPAA Legislation called for the development of a National Individual Identifier for Health Care Transactions and Code sets.

3) Would MMSEA 111 be able to function with the National Individual Identifier instead of the Social Security Number?

4) Why hasn't development of a National Individual Identifier been completed and when can we expect it?

Jonathan Hale Ó¿Õ¬
AMISYS Special Projects Manager
Health New England
(413) 233-3594
mailto:jhale@hne.com
http://www.healthnewengland.com

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," w*ouldn'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: Walter Pregizer [WPregizer@KeenanAssoc.com]
Sent: Monday, September 29, 2008 7:31 PM
To: CMS PL110-173SEC111-Comments
Subject: #130 [collection of ssn] Implementation of Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
Attachments: Walter Pregizer.vcf

In trying to collect HCIDs or SSNs from covered dependents, some employees/members won't comply. How will are we to handle these situations? Are we mandated to collect this information?

Walter T. Pregizer
Vice President
Keenan
Phone: (310) 212-0363 x3223
Fax: (310) 533-2995
CA License No. 0451271

PARHAM, WILLIAM N. (CMS/OSORA)

From: Daniel Kopti [dan@abdi.com]
Sent: Monday, September 29, 2008 8:03 PM
To: CMS PL110-173SEC111-Comments
Subject: #131 [RRE requirements - ssn collection] Question about Employees' Refusal to Disclose Dependents' SSNs

Please address the following question during the teleconference on Wednesday:

> If an RRE asks an employee to disclose his/her dependent's Social Security Number, and the employee refuses, what is the RRE required to do to comply with its reporting obligations under section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007?

Thank you for your help.

Daniel

Daniel Kopti | Compliance Manager

ABD Insurance and Financial Services (A Wells Fargo Company) | Employee Benefits | California Life Agent License No. 0F44780 | Office: (310) 543-9995 | Fax: (310) 553-9905 | 21250 Hawthorne Blvd, Suite 600, Torrance, CA 90503

PARHAM, WILLIAM N. (CMS/OSORA)

From: Sarah Gaidos [SGaidos@nqbp.com]
Sent: Monday, September 29, 2008 11:51 PM
To: CMS PL110-173SEC111-Comments
Subject: #132 [mulitple questions] Section 111 comments
Attachments: Comments.doc

Dear Sir or Madam,

Please accept the attached as NuQuest/Bridge Pointe's "comments" regarding CMS' proposed guidelines to implement Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) as contained in the Federal Register (73 Fed. Reg. 45013, August 1, 2008) and CMS' "Supporting Statement" issued concomitantly therewith.

Sarah Gaidos
Sales & Marketing Coordinator
P. 321-460-5054
F. 321-460-5154
866-858-7161, 4854
http://www.NQBP.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: Poland, Ann [apoland@coresource.com]
Sent: Tuesday, September 30, 2008 7:31 AM
To: CMS PL110-173SEC111-Comments
Subject: #134 [Alien residents]

Sir/Madam:

Another question that has come up is in regard to those people who don't work and therefore don't have a social security number. Perhaps they are immigrants. Their spouse works and they stay at home and don't get a social security number. How is this to be handled?

Sincerely,

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: Ewing, Mike [mewing@unitedactuarial.com]
Sent: Tuesday, September 30, 2008 10:23 AM
To: CMS PL110-173SEC111-Comments
Subject: #136 [GHP - SSN reporting] SSNs of non-working over 65 retirees

Do GHPs need to report the SSNs of non-working over 65 retirees covered under the GHP's retiree coverage?

It appears that the Basic format is for "actives" and the Expanded format includes non-working over 65 retirees covered under the GHP's retiree coverage. Could you be more explicit?

Thanks!

PARHAM, WILLIAM N. (CMS/OSORA)

From: Vendette, Linda [lvendette@thezenith.com]
Sent: Tuesday, September 30, 2008 11:44 AM
To: CMS PL110-173SEC111-Comments
Cc: Kelly, Kimberley; Guttormsen, Pat
Subject: #138 [NGHP - timeline, access data, compliance, etc.] Questions on the Mandatory Reporting - for Open Door Forum Teleconference

Please find below questions in reference to the Mandatory Reporting Requirements.

1. When will the Non GHP data specifications and implementation guide be available?

2. Will VDSA or an alternative form of query to access Medicare Entitlement Data be available to Non GHP's? How can we obtain further information into establishing an agreement? Is there any other method available to obtain confirmation of Medicare Beneficiary status without a signed release from potential beneficiary if they are not cooperative?

3. How will compliance be determined? What criteria are being used to determine late reporting? There are no data fields which document RRE's receipt of claim and/ or date verifying Medicare Entitlement.

4. Please clarify frequency of reporting. Will reporting be accepted only quarterly or can claims be reported more frequently.

5. How should delayed claims be reported? These cases are accepted while claim is under investigation.

6. Claims Resolution -Under WC the majority of the Non- Contested cases resolve with RTW and subsequent closure. Therefore, which option should be selected when there is no resolution by way of settlement?

Linda Vendette

Zenith Insurance Company

phone: 941-906-5534

fax: 941-906-4383

lvendette@thezenith.com

****

****

PARHAM, WILLIAM N. (CMS/OSORA)

From: Linda Ludwick [lludwick@mymsas.com]
Sent: Tuesday, September 30, 2008 11:45 AM
To: CMS PL110-173SEC111-Comments
Subject: #139 [NGHP ssn collection timeframe] Employer information

As a TPA (third party administrator) who holds information on our clients, most all do not gather information regarding dependents and their insurance coverage. I am worried that the time frame for reporting does not allow the employers apt time to obtain this information for us. As the TPA are we then liable?

Linda Ludwick | Executive Director

MOUNTAIN STATES
ADMINISTRATIVE SERVICES

7202 E. Rosewood, Suite 200
Tucson, AZ 85710
520.722.7103 phone
800.866.4731 x142 toll free
520.722.7127 fax
lludwick@mymsas.com
www.mymsas.com

EXCEPTIONAL SERVICE...DELIVERED BY EXCEPTIONAL EMPLOYEES

PARHAM, WILLIAM N. (CMS/OSORA)

From: Bucksner, Michael [mpbucksner@cvty.com]
Sent: Tuesday, September 30, 2008 12:10 PM
To: CMS PL110-173SEC111-Comments
Subject: #140 [NGHP - disputes, queries, compliance] Open Door Forum 10/1/08

Please consider these questions in tomorrow's forum:

- Will ASO vs. Fully insured Employer groups need separate agreements?
- Will Insurers receive an alert **that specifically states** they will be compliant with MSP reporting by submitting an application before 10/31/08 even if files are not being sent until after 1/1/09?
- How many BASIS queries per month will CMS allow?
- What is the process for handling disputes between members' information and CMS' data?

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

The American Insurance Association's Response to Request for Comments on the

SUPPORTING STATEMENT FOR THE MEDICARE SECONDARY PAYER (MSP) MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007 (MMSEA) (P.L. 110-173) See 42 U.S.C. 1395(b)(7) and (8). (CMS-10265)

Introduction

The American Insurance Association (AIA) is the leading property-casualty insurance trade organization, representing 350 insurers that write more than $123 billion in premiums each year. AIA member companies offer all types of property - casualty insurance, including personal and commercial auto insurance, commercial property and liability coverage for businesses of all sizes, workers' compensation, homeowners' insurance, medical malpractice coverage, and product liability insurance. AIA is pleased to offer its comments on behalf of its membership. Our comments will be directed to the necessity of the data, the efforts of CMS to date, the burden on the property/casualty industry, the need for CMS to better understand the industry, the need to properly define situations, and use common definitions. Comments, concerns and questions are noted in *italics for each section of the CFR.*

A. Background

Comment: We estimate that the scope of the section on Non-group Health Plans (NGHPs) captures in excess of 40 million claims annually. This is an estimate because there is no one means to determine exactly how many given the current regulatory scheme for property-casualty insurers. This estimate does not capture the number of claims of self insureds. In addition, the CMS definitions regarding property-casualty insurance in the CFR do not reflect generally accepted definitions used in the property-casualty industry for the lines of business and the types of policies that are covered by the Act. For example, the CFR definition includes property damage under liability claims dealing with bodily injury. These definitions reflect a lack of understanding of the property- casualty industry as well as risk transfer methodologies in place within the United States today. Overall, this underlying problem, along with the current lack of specificity in other parts of the CFR, creates more confusion, uncertainty, and frustration within our membership over their ability to move forward at this time to comply with the law. There is no clear understanding of what will be reported and when and why some of the data is needed.

1. Purpose

Comments: If the purpose was to set forth what information will be collected and the process for such collection the CFR fails to do so with the specificity necessary to enable required reporting entities to begin to plan and act to comply with the law. The CFR does not define crucial items, allows for assumptions, and is confusing as to time- frames and fails to answer operational issues.

The NGHP date of reporting is 07/01/2009. Property-casualty insurance is purchased by individuals or businesses for specific periods of time and covers incidents as defined by individual policies. The document does specify undefined data to be reported, but ignores from which claims, i.e. open, closed, only those with dates of loss after 07/01/2009, etc.

2. The Federal Role

Comments: It would be helpful if the contractors with whom the property-casualty industry will be dealing with are identified and included in all communication efforts so that issues are not lost in the translation from the industry to CMS to the contractors.

The CFR states that non-NGHPs should already be collecting most of the information that CMS will require in connection with Section 111, MMSEA. This is an opinion stated as a fact but is inconsistent with our understanding of the actual information being collected. Even if NGHPs are collecting some of this data, it is in individual claim files without the ability to easily aggregate or report electronically.

3. Current MSP Information Gathering Processes

Comment: The current Pre-payment activities referred to apply to GHPs and beneficiaries, not to non-GHP entities.

Comment: With regard to Post-payment activities, the current debt recovery creates a burden on property-casualty insurers. To ensure the accuracy of the contractor's request, the reporting entity is required to review each payment request for errors and unrelated bills.

C. Justification

1. Need and Legal Basis

No Comment

2. Information Users

Comment: CMS should allow for outside comments when the registration website is available. We agree that property-casualty insurers should submit electronically and it should be the format of their choice from the three options allowed. Given that the current time line states that the registration will not begin until May 2009, it is difficult to conceive that the reporting of data can reasonably begin by 10/1/2009.

3. Improved Information Technology (IT)

Comment: This provides relief to CMS and GHPs but has no savings for NGHPs, as they are not currently required to report or do not participate in the voluntary reporting procedures.

4. Duplication of Similar Information

Comment: As stated above this does not relieve the property-casualty industry of any burden.

5. Small Business

Comment: The property-casualty industry is very diverse and there are a large number of small companies. The costs of the new reporting requirements are disproportionately greater on the smaller property-casualty companies.

6. Collection Frequency

Comment: The collection frequency is confusing. First, it provides that the collection will be quarterly, but then states that for certain types of non-GHP data it will be on an ongoing basis. There is no description of what is meant by ongoing. Is this daily, weekly, when a claim is paid, when a bill is paid? Is the industry to decide?

7. Special Circumstances

Comment: Extending the record retention to 10 year adds over 200 million claims for ten years (assumes approximately 40 million claims per year) over that period.

What is MSP related information?

The scope of the new reporting requirements is limited to reports due on and after July 1, 2009. Retention requirements associated with this requirement should take effect on or after July 1, 2009 and be limited to the information provided in the applicable reports.

8. Federal Register Notice/Outside Consultation

Comment: The web page initially was not operating properly.

Comment: Although the American Insurance Association participated in three listening sessions and facilitated discussions with CMS and the Insurance Services Organization (ISO, this document does not reflect the numerous issues raised in those discussions, how they can be resolved, the costs associated with the mandatory reporting nor the data fields made available for us to review and comment upon.

9. Payments/Gifts to Respondents

No Comment

10. Confidentiality

Comment: Confidentiality is attached to the requested information as it was initially obtained. This confidentiality should continue in effect, as the information is reported to CMS and should not be preempted by the CMS administrative reporting requirements. There should be immunity from suit related to data revelation for parties who release information to CMS in accordance with its requirements and it cannot be used for any other governmental processes. In addition, this data is the property of the required reporting entity and should be treated as such. Reporting this data to CMS does not turn over ownership of the same.

11. Sensitive Questions

No Comment

12. Burden Estimate (hours and wages)

Comment: There is an assumption that, "many of the data elements .....are required for internal business purposes." Each NGHP is an individual business with its own business requirements, data, processes, and business model. This assumption again indicates a lack of understanding of the property casualty industry and its business practices and the burden of this reporting requirement.

Comment: CMS makes assumptions that are not necessarily correct; therefore it can not properly estimate the burdens it is placing on the industry. Since CMS is a secondary payer for a considerable amount of time the property-casualty industry has been making primary payments quickly and efficiently in time- frames that do not allow providers to request conditional payments. Most providers prefer to be paid at a higher rate therefore they are diligent in presenting bills quickly to the property casualty industry.

NGHPs do not operate like group health insurance plans. This section quotes the same language as in the GHP material. Since CMS does not know how the property-casualty industry operates it quoted the same language as in the GHP material. For business purposes, property-casualty insurers have multiple systems with multiple interfaces. A project to collect data that is not currently collected in the manner required by CMS is complex.

CMS states that there that there are 400 entities that will be required to report. There are over 800 insurance groups in the United States and this does not take into account that the reporting requirement includes self insureds as well. .

The individuals who will be required to collect social security numbers in the property-casualty industry are adjusters, a salaried position, with an annual average salary in excess of $40,000. Entry level adjusters earn over $30,000.

In order to comply with the statute every claimant must report their social security number so as to determine if they are a beneficiary. That changes the number of claims to at least 40 million.

At first, training will be needed to inform adjusters to secure social security numbers and dates of birth on all potential beneficiaries. Communication with stakeholders will be needed so that they understand the reporting requirements and auditing will be needed to ensure compliance. None of these costs are in the estimate.

CMS does not account for the potential reluctance of an undocumented claimant, who is by right allowed to bring claims, or for parties who will not, for whatever reason, release the information. Non-GHP entities cannot compel a beneficiary to provide Medicare eligibility information absent a lawsuit. Even using CMS 5 minutes which they use for GHP, who have the number in their systems, the math should read:

SSN Collection 5 minutes x 40 million =200million minutes =3,333,333 hours x $20 an hour = $63,333,333

375 x 800 = 300,000 x $20 =$6,000,000
664,302 x $20 = $13,286,040 or a total burden of at least $76,619,373 on just the 800 property/casualty groups not including self- insured. Given that CMS was given $35,000,000 for itself this estimate of $76.6 million is very conservative, but it is 6 times CMS's estimate of $12.6.

Note that in this NGHP section CMS reverts to GHP and discusses the time needed to complete a task in terms of GHPs not NGHPs. This is another example of assuming that GHPs and NGHPs operate in the same manner, which they do not. It has not even been designed when the document was written. This speaks to the thought and effort as well as editing that went into this estimate.

13. Capital Costs

Comment: The new reporting requirements will require NGHPs to reformat their IT systems to comply. This will require substantial, new capital costs.

14. Cost to Federal Government

Comment: There is an interesting lack of back up to this estimate. Given 800 insurer groups instead of the CMS estimate of 400, it would appear that annual ongoing maintenance and support costs for this activity will be over $16 million.

15. Program Changes/Changes in Burden

Comment: Again as stated under item 4 this does not relieve the property-casualty industry of any burden.

16. Publication and Tabulation

Comment: Since this data is not owned by CMS, it should not publish or tabulate the information received for statistical purposes.

17. Expiration Date

No Comment

18. Certification Statement

No Comment

D. Statistical Methods

No Comment

Attachment A – Definitions and Reporting Responsibilities

SUPPORTING DOCUMENT FOR PRA PACKAGE FOR MEDICARE SECONDARY PAYER REPORTING RESPONSIBILITIES FOR SECTION 111 OF THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

DEFINITIONS AND REPORTING RESPONSIBILITIES

LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION (42 U.S.C. 1395y(b)(8) --

INSURER'
For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is 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 processing; 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 claim processing.

CLAIMANT:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 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)".
Comment: We recommend that the definition include, an individual asserting a right for a suffered [bodily injury] loss or other loss requiring medical attention.

APPLICABLE PLAN:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)((F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer's insurer.
Comment: Although the law references plans, the property-casualty industry writes and sells policies not plans, this should be changed to reflect that fact.

NO-FAULT INSURANCE:
Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.
Comment: CMS indicates that they know that their definition is not one used by anyone in the property-casualty industry but goes forth with their own. We would recommend that CMS use the usual and customary definitions used by the property-casualty industry

for defining all types of insurance that is covered by the reporting requirement to avoid confusion.

LIABILITY SELF-INSURANCE:
42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession. See also 42 C.F.R. 411.50.

SPECIAL CONSIDERATIONS WHERE LIABILTY SELF-INSURANCE WHICH IS A DEDUCTIBLE OR CO-PAYMENT FOR LIABILTY INSURANCE, NO-FAULT INSURANCE, OR WORKERS' COMPENSATION IS PAID TO THE INSURER OR WORKERS' COMPENSATION ENTITY FOR DISTRIBUTION (RATHER THAN DIRECTLY TO THE CLAIMANT):
As indicated in the definition of "liability self-insurance," such deductibles and co-payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two 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 part of the insurer or TPA's report. CMS specifically seeks comments on this approach. If this approach is not adopted, both entities will have to report in this situation. Regardless of the final decision on this approach, CMS may need to add a few additional data elements (in the form of a question or otherwise) so that it will clearly be able to identify such situations.

Comment: If the claim is handled by an insurer or TPA on behalf of an insurer and the reimbursement occurs after the claim has been resolved and paid, the insurer should report the claim. In the case of self-insured retentions where the claim is handled by the self-insured and the insurer makes payment to the self–insured rather than a claimant, the self insured or their TPA should report to CMS. The question arises if the claim is reinsured, does the reinsurer report the same claim? As was stated in the listening sessions, CMS should prepare to receive the same report from multiple insurers.

WORKERS' COMPENSATION LAW OR PLAN
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), a workers' compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the

employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(8):

Agents may submit reports on behalf of:

- Insurers for no-fault or liability insurance
- Self-insured entities for liability insurance
- Workers' compensation laws or plans

Comment: An entity should also be allowed to report "no-fault" claims for a self insurer.

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

TPA's of any type (including TPA's as defined for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7) for GHP arrangements) have no reporting responsibilities for purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8) for liability insurance (including self-insurance), no-fault insurance, or workers' compensation. Where an entity reports on behalf of another entity required to report under 42 U.S.C. 1395y(b)(8), it is doing so as an agent of the second entity.

CMS will provide information on the format and method of identifying agents for reporting purposes.

Attachment B
The Need for Social Security Numbers and/or Health Insurance Claim Numbers

The Centers for Medicare & Medicaid Services (CMS) seeks to collect various data elements from the applicable reporting entities for purposes of implementing the mandatory Medicare Secondary Payer (MSP) reporting requirements of Section 111 of the Medicare Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173). The reporting of Social Security Numbers (SSNs) or the associated Medicare Health Insurance Claim Numbers (HICNs) is critical for coordination of benefits.

The SSN is used as the basis for the HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet it administrative responsibilities to pay for health care and operate the Medicare program. Pursuant to 42 U.S.C. 1395y(b), Medicare is the secondary payer to GHP coverage under certain circumstances and to liability insurance (including self-insurance), no-fault

insurance, and workers' compensation. The SSN or HICN is the cornerstone of the administration of the Medicare program. Medicare uses an individual's SSN or HICN to ensure that Medicare makes payment in the proper order and/or takes the necessary recovery actions. Absent the SSN or HICN, CMS would not be able to systematically link the reported data to a particular Medicare beneficiary.

We understand that some individuals may be hesitant about providing their SSNs. CMS recognizes that the collection and use of individual SSNs is limited by an evolving body of federal and state law and regulation. When an SSN is to be used for personal health information, management of the SSN (e.g., who can collect it, for what reason and with what other entities or persons will it be shared) is directed by regulations required by the federal Health Insurance Portability and Accountability Act (HIPPA). These regulations are referred to as the HIPAA privacy rules. These rules are quite strict, and after they were fully implemented in 2004 measures to protect personal health information became stronger. Collection of SSNs for the purposes of coordinating benefits with Medicare is a required, legitimate and necessary use of the SSN under Federal law.

We also note that there are some state laws that restrict when SSNs can be collected and how SSNs can be used. These state initiatives do not preempt the MSP statutory or regulatory provisions or the "permitted use" provisions of the HIPPA privacy rules. These referenced federal laws allow for the collection and use of the SSNs to help providers and insurers manage their operations. Some states now restrict how SSNs may be displayed, such as prohibiting a health plan from including an SSN on an individual's plan ID card. Such state laws are permissible, to the extent they augment but do not conflict with or constrain the requirements of federal laws or regulations.

Comment: *When or if suit is brought against an insurer within the property-casualty insurance industry, it is expected that this document will be entered into evidence and an individual be presented to testify in support of its findings.*

Attachment D
NGHP Data Elements

Non-GHP
Data Elements Input File

Injured Party (The injured party is/was a Beneficiary)

1. Last Name (Mandatory)
2. First Name (Mandatory)
3. Middle Initial (Optional)
4. Address (Mandatory)
5. Telephone (Optional)
6. Email (Optional)

7. Date of Birth (Mandatory)
8. Date of Death [DOD] (Situational) *Comment: Situational needs to be defined for all of the data elements*
9. Gender (Mandatory) *Comment: This should include unknown*
10. Social Security Number (Situational) ***[Mandatory if HICN not provided, pseudo SSNs not permitted]***
11. Beneficiary HICN (Situational) ***[Mandatory if SSN not provided Pseudo HICNs not permitted]***

Claimant, if different than Injured Party (Claimant is Medicare Beneficiary's estate, wrongful death claimant other than estate, survivor action and claimant other than estate)

Comment: Please clarify what is being requested. Liability claims are established under the name of the individual including fatalities. Adding additional parties will have down stream effects in frequency of loss, actuarial reserving, rate making, and regulatory compliance.

[All items noted as situational, only needed when claimant not the Injured Party]

12. Beneficiary Relationship (Situational) ***[Estate/Spouse/Child/Sibling or Other]***
13. Name and Address (Situational) *Comment: This not usually known in mass torts or class actions.*
14. Telephone and/or Email (Optional)
15. TIN [SSN or EIN] (Situational) ***[Pseudo SSNs or EINs not permitted]***

Primary Plan [Separate Report for Each Plan and/or Insurance Type]
[If settlement for more than two individuals must report separately]

Comment: 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 necessarily sold on a "group" basis, but rather on an individual or company entity basis. Even when a group policy is sold in p/c, it is not referred to as "plan."

16. Insurance Type (Mandatory) ***[Workers' Compensation, Liability or No-Fault]*** *Comment: This should be by line of business not by CMS' definitions. CMS will receive duplicate claims as an individual can no fault" and liability claims or workers compensation and liability claims.*
17. Name (Mandatory) ***[Legal Name]*** *Comment: Is this the insurance group name or the underwriting company name?*
18. Address (Mandatory)
19. TIN [SSN or EIN] (Mandatory) ***[Pseudo SSNs or EINs not permitted]*** *Comment: Is this the p/c insurer's TIN?*
20. Additional Information (Optional) *Comment: This field should be deleted since it is undefined.*
21. Policy Number (Mandatory)

22. Claim Number (Mandatory) ***[Internal claim number]***
23. No fault Policy Limit (Situational) ***[In No-Fault]*** *Comment: Some no fault coverages have no limit while others have sub-limits.*
24. Exhaust Information (Situational) ***[In No-Fault; Report date only if benefits are fully exhausted]***

Policy Holder

25. Policy Holder Name – Legal Name (Mandatory) *Comment: Why is this needed?*
26. Policy Holder Name – DBA Name (Mandatory) ***[May or may not be the same as legal name]*** *Comment: Why is this needed? The insured's name is proprietary to the insurer and collection cannot be pursued against them. This is an invasion of their privacy right. Both 25 and 26 reflect how GHPs operate not NGHPs.*
27. Self-Insured (Mandatory) ***[Yes or No? Applies to WC and Liability. See supporting document for full explanation of the term "liability self-insurance."]***

Injured Party or Claimant Attorney/Representative
[All items noted as situational applicable when there is an Attorney]

28. Attorney Name (Situational)
29. Firm Name (Situational)
30. Attorney Address (Situational)
31. Attorney Telephone and/or Email (Optional)
32. "Attorney" TIN [SSN or EIN] (Situational) ***[Pseudo SSNs or EINs not permitted; TIN for individual attorney or firm dependent on which is listed as a payee]***
33. State Bar Member Number and State (Optional)

Incident

34. Date of Injury (Mandatory) ***[For an automobile wreck or other accident, the DOI is the date of the accident. For claims involving exposure, the DOI is the date of first exposure. For claims involving ingestion (for example a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).]*** *Comment: Within the p/c casualty industry it is usual and customary to determine the date of last exposure for workers compensation claims as well as liability claims so as to determine the priority of coverage, first exposure is often unknown. State laws impose liability on the date of last exposure, not the date of first exposure; therefore p/c insurers typically use the date of last exposure for the date of injury? The injury date vary depending upon what date the jurisdiction uses p/c insurers will have no ability to easily locate and provide the date of first exposure. Implants are used to facilitate an injured party's healing process. If this is a reference to product liability claims arising from implants it should be stated.*
35. Nature of Injury (Situational) ***[WCIO Nature of Injury Table]*** *Comment: WCIO tables are not in general use within the p/c industry in claim systems or in liability and "no fault" claims. This puts a burden on the entire*

industry to change their front end systems and the recode their entire inventory before any reporting can occur.

36. Cause of Injury (Situational) ***[WCIO Cause of Injury Table]***
37. State of Venue (Mandatory) *Comment: Does this refer to loss location or litigation venue? Would it be benefit state for No-fault and workers compensation claims?*
38. ICD-9 Code [Up to 5 occurrences] (Situational) ***[At least 1 ICD-9 Code or Body Part Code]*** *Comment: Captured by only some insurers and only in some workers compensation claims, usually only one is captured.*
39. Body Part [Up to 5 occurrences] (Situational) ***[WCIO Body Part Code Table; At least 1 Body Part Code or ICD-9 Code]*** *Comment: Define situational as it applies to these data elements, when are any of these required? These are usually not obtained in liability and "no fault' claims.*
40. Product Liability (Mandatory) **[Yes or No]** *Comment: This appears to be included due to an interest in pursuing potential class actions involving pharmaceutical and medical devices. If so word it that way. Note that these will only be reported after the settlement, judgment, or award.*
41. Product Liability Information (Situational) **[If #43 is yes, provide Product generic name, brand name and manufacturer. Also describe alleged harm (free form space provided)]** *Comment: Given that you reference number 43 there apparently were two data points on the list before this one. Sending free form data creates quality issues as well as the fact that someone on the other end needs to read it.*

Resolution

[All items noted as situational only applicable when a contested claim has been resolved(vs. responsibility accepted without contesting the matter)]

42. Settlement Date (Situational) **[Date of Settlement, Judgment, Award or Other payment]** *Comment: Is this the date the settlement was reached or the date the payment was made?*
43. Amount (Situational) **[Amount of Settlement, Judgment or Award]** *Comment: Often settlements are confidential; this document does not address that aspect. If the settlement involves multiple insurers does the insurer report only their contribution or the total amount of the settlement from all parties which they may not know? In cases of a structured settlement, what is the settlement amount? Is it the periodic benefit, or the value of the structure?*
44. Claim Resolution (Mandatory)
    - Contested, resolved claim with no on-going responsibility
    - Contested, resolved claim with on-going responsibility
    - Non-contested claim with on-going responsibility
    - Non-contested claim, resolved with no on-going responsibility

    Comment: Define on-going responsibility. Define contested vs. non-contested. This does not seem to contemplate mass torts or class actions.
45. Funding (Situational) **[Was funding of the settlement, judgment, award or other payment contingent upon proof of resolution of Medicare's fee for service Medicare Secondary Payer recovery claim? Yes or No.]** *Comment: Define situational,*

does this mean you think all claims must request proof of resolution? This is generally not obtained in liability claims.

ADDITIONAL COMMENTS:

ISO has indicated that they have found 10 data elements that are not currently in their Universal Format. This creates a burden for the industry to program their systems to capture these elements.

Without the record layout and further information it is currently impossible to create a project team to begin working to comply with the reporting requirement. If the record layout is one used in the GHP environment and not in the p/c world, the size and costs of individual company's IT projects will rise dramatically. CMS should allow for further comments when the record layout is released.

Members respectfully disagree and strongly differ with CMS statement that the collection of data and its transmission will not cause an undue burden to the reporting entity. One member reports that nineteen of the data elements are not currently captured in their systems. In addition, 10 more data elements are not currently reported through ISO, if it becomes the reporting resource.

Under the new timeline presented, what will a company be responsible for during the testing period?

In conclusion the cost and time associated with this new reporting requirement is significant to every member company, their employees as well as their sales forces and the general public. Every regulator in every state as well as all members of the bar will need to be educated on the implications of this new reporting requirement. It will be left to the companies' adjusters to do it one claim at a time since claimants will be unfamiliar with it as well as the consequences.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Ziegler, Janice H. [jziegler@sonnenschein.com]
Sent: Tuesday, September 30, 2008 1:06 PM
To: CMS PL110-173SEC111-Comments
Subject: #142 [Ziegler Atty. mix of non section 111 & section 111 NGHP Qs] Questions for CMS Open Door Forum Teleconference for Medicare Secondary Payer Mandatory Reporting

We greatly appreciate CMS' willingness to host an Open Door Forum Teleconference on October 1, 2008 concerning the Medicare Secondary Payer Mandatory Reporting Process for group health plans, liability insurers, no fault insurers and workers compensation plans. It will undoubtedly be very helpful to receive a status update from CMS regarding its implementation plans for mandatory reporting and to obtain answers to questions regarding the self-reporting process and related matters. In this regard, we submit the following questions for discussion by CMS:

1) Is CMS anticipating establishing a two-way data exchange in the Liability Insurer context to allow insurers to determine whether a particular claimant is Medicare entitled? If so, when is it anticipated that this process will come on-line?

(2) If not, will it be acceptable for Liability Insurers to be over inclusive in their reporting (i.e., provide mandatory data elements for all settlements involving claimants or all settlements involving claimants over a certain age) to ensure that they report in relevant instances (given that it is difficult to obtain reliable Medicare entitlement information)?

(3) Is CMS anticipating establishing a more formal and timely process for Liability Insurers to determine the amount of any claimed Medicare conditional payments that may have been made with respect to a particular claimant who is a Medicare beneficiary?

(4) When will Medicare issue the model beneficiary information collection form referenced on the CMS MSP Mandatory Reporting website?

(5) Will data supplied by Liability Insurers (such as field 44/contested claim) be publicly disclosed to others, upon request?

(6) How can a Liability Insurer ensure that the COB file on the Common Working File is closed when settlement occurs?

(7) Will Reporting Entities be able to choose the date of their periodic (presumably quarterly) reporting or will all entities be required to report on the same day?

(8) When does CMS anticipate that the User Guide for Liability Insurers will be available?

Thanks in advance for your consideration of these questions.

Best regards, Janice

Janice H. Ziegler, Esq.
Sonnenschein Nath & Rosenthal LLP
1301 K Street, N.W.
East Tower

Washington, D.C. 20005
(202) 408-9158 (office)

PARHAM, WILLIAM N. (CMS/OSORA)

From: Toni McMurry [tmcmurry@keenan.com]
Sent: Tuesday, September 30, 2008 1:20 PM
To: CMS PL110-173SEC111-Comments
Cc: Walter Pregizer; Savannah Greene
Subject: #143 [GHP(?) data elements &date for instructions] Question for Tomorrows Teleconference

1)When Will Medicare release more definitive reporting requirements.

Questions from Attachment C GHP Data elements

#9 Coverage Type (Type of Insurance Coverage) Are you wanting to know if the carrier supplies Medical, Dental, Vision or Pharmacy?
#20 Employee Election coverage (Who the policy Covers) are you wanting all of the dependents to be listed?
#21 Employee Status (Reason Why GHP is Primary) Are you wanting to know if the member if the policy holder or covered dependent are under 65, or ESRD under 30 months, or the number of employees qualifies the GHP as primary? If so, is there a specific format or code you will be requiring us to use?

Toni McMurry
Manager, TPA Operations
Keenan & Associates
(310) 212-0363 ext. 3318
mcmurry@Keenan.com
License#0451271

IN RESPONSE TO THE
MEDICARE SECONDARY PAYER (MSP)
MANDATORY INSURER REPORTING REQUIREMENTS OF SECTION 111 OF THE MEDICARE MEDICAID, AND SCHIP EXTENSION ACT OF 2007 (MMSEA) (P.L. 110-173)
See 42 U.S.C. 1395(b)(7) and (8).
(CMS-10265)

Technical:

- Non-GHP insurers do not operate in the same manner as GHPs. GHPs typically do all of their claims processing in-house, and receive their claims from a handful of large TPAs. As a Non-GHP, we use several dozen TPAs, each handling some or all of claims for our products. This means we have to get each TPA to update & test their claims feeds in order to ensure they capture the data required by CMS by the required deadline. There are also additional regulatory projects underway for non-CMS related legislation that will compete internally for the same resources, which is why the timeframe is currently unreasonable and should be extended.
- We have more than one claims system- in our case, we have four legacy claims systems that will require screen changes, database changes, and full testing to ensure the new elements do not impact other processes.
- We are currently reviewing the legislation and have roughly estimated the changes required to support this legislation to be from $1,000,000 to $1,500,000 when factoring in legal interpretation, business analysis review, requirements development, technical analysis, data gap analysis, IT systems design, database architecture changes, screen changes on several claims systems, software development, testing, and implementation, data transmission charges through proposed vendor(s), receipt and analysis of data returned by CMS, additional document retention charges, additional data storage charges, file transfer support, production support fees by our IT partners, management oversight, and operational changes required to support additional data gathering needs.

1. Will CMS accept data submissions from different sources for claims from the same carrier?
2. Is CMS appointing an intermediary for claims feed and any CMS responses?
    a. A web-based data-entry solution will not suffice due to the volume of claims.
3. The present Voluntary Data Sharing Agreement is not designed for Non-GHP entities and needs revision to allow for safe harbor in capturing Medicare eligibility data to avoid HIPPA implications as well as account for the use of Third Party Administrators in the process.
4. CMS has developed reporting requirements which are HIPAA compliant, yet Workers Compensation is not covered by HIPAA. CMS is enforcing a standard which does not exist.
5. Mandatory Insurer Reporting, per CMS, can be done online, but there is no application available.
6. Non GHP entities is required to register online, yet no website exists.
7. Reporting is to be done electronically, yet no data layout exists.
8. What is CMS' policy regarding unmatched data? How is legal responsibility for data breaches assigned?
9. What are the document retention rules for documentation associated with this process?
10. **Data element 10- Social Security Number: Question-** what if the injured worker did not have a valid social security number, or refuses to provide it?
11. **Data element 11-Beneficiary**: Question-on initial reporting on fatal claim beneficiary information may not be fully available, what is an appropriate answer?

12. What is an appropriate answer on initial reporting on a fatal claim where the alleged beneficiary has no actual proof of marriage, dependency?
13. On initial, interim/final reporting what is the proper answer for a common law spouse?
14. **Data element 36 Nature of Injury** Question- in occupational diseases claims where more than one body part is alleged to be injured what is an acceptable answer to nature of injury?
15. In cumulative trauma claims where more than one body part is alleged to be injured what is an acceptable answer to nature of injury?
16. **Date of Injury:** CMS has decided that "for claims involving exposure, the date of injury is the date of the first exposure." This definition may lead to unintended consequences as to the applicability of insurance coverage under state law for liability cases and in the worker's compensation arena may conflict with disease laws where the date of injury is the Date of Disablement.
17. **Data element 37 State of Venue: Question**-is this defined as the state that has the jurisdiction over the workers compensation claim?
18. How should US Longshore & Harbor Workers or Defense Base Act claims be shown in the jurisdiction as they are not "states"?
19. In the initial phase of a claim what answer as to jurisdiction is appropriate when an injured worker is injured in one state, but is attempting to secure benefits in another state or where there is a dispute as to whether jurisdiction is in fact a state or perhaps a US Longshore & Harbor Workers claim? While those situations would be resolved at time of settlement (if applicable) for the initial reporting it may not be.
20. **Data element 42- Settlement Date: Question**-in jurisdictions (Pennsylvania example) where the injured worker has returned to work and the comp statute doesn't provide for any further indemnity benefits (such as permanent partial disability) there is no " settlement" per se. Assuming no further medical treatment the file would thus be ready to be closed. In this example please provide a definition as to "settlement date"
21. **Data element- 43 Amount: Question**-using the example above, where there is no award/judgment/settlement and file is ready to be closed what amount would be entered? Would it be the total indemnity/lost wages paid? Would the amount be inclusive or exclusive of total medical payments?
22. **Data element 44- Claim Resolution: Question**-using the same example cited above absent any award/judgment/settlement and the file was not contested or litigated is it appropriate to enter non-contested claim resolved with no-ongoing responsibility?

Operations & Reporting:

- Claims in the Non-GHP are not as clear-cut as in the GHP environment. A claim can be resolved but not closed - as in the case of workers compensation, ongoing payments can be made for years.
- CMS' statement that "For most non-GHPS, gathering the data required for MIR will not be a considerable burden. Because the applicable reporting entities have had a long-standing obligation to coordinate claims payment with the Medicare program and to pay clams for health care in the proper order, CMS must assume the Non-GHP entities currently collect the data required for reporting." There has not in fact been a "longstanding obligation" to make this determination; in fact, that "obligation" has only been in place approximately six months due to vagaries in the previous legislation that were never clarified. As such, we contend this legislation will place a heavy burden to capture previously unnecessary data elements and analyze, design, code, test, implement, and support processes in several

enterprise-wide claims systems, as well as analyze, define, and update our claims organizations' operational policies.

23. How does CMS reconcile their requirement for affected Plans to report potential third-party claims involving Medicare beneficiaries or potential beneficiaries (and will be severely penalized for failing to do so), while at the same time they are deprived of any mechanism short of litigation or voluntary provision by the beneficiary (in a sometimes hostile environment) to allow the Insurer to lawfully collect the information?
24. How is A NON-GHP to determine who is entitled to benefits under Medicare?
25. How will CMS track claims that have multiple medical payments?
26. At what point of the claim lifecycle is A NON-GHP to make this determination?
27. What is the process and burden on A NON-GHP for handling incorrectly reported information to A NON-GHP by the insured?
28. In section 5 of the Support Statement, how did CMS determine that "... relatively few small businesses will be impacted by this legislation" when Non-GHP claim complexity has no relation to a company size?
29. What is the requirement for reporting?
    a. On claim open
    b. On claim paid
    c. On claim closed
30. What does "resolved" mean (i.e., report to CMS when claim is resolved)?
31. What is the scope of liability reporting?
32. Excess coverage
33. Umbrella coverage
34. Why is the sharing of information different between GHP and Non-GRP?
35. How are compromised settlements to be reported, where the medical benefit is wrapped into the overall settlement amount?
36. Are US citizens injured when outside the US included?
37. In multiple defendant litigation, what is the reporting requirement for mass tort, risks with different layers of coverage, and class action claims?
38. In section 6 of the Supporting Statement, CMS requests ongoing and one time basis reporting. Is data for each Non-GHP claim expected to be appended or cumulative?
39. There is no requirement to report liability claims on an ongoing basis. In cases of a structured settlement, what is the settlement amount? Is it the periodic benefit, or the value of the structure?
40. Is the quarterly reporting requirement a maximum or minimum requirement?
41. Does CMS expect both ongoing and one time basis payments to be reported at the same frequency?
42. What is the recovery process workflow and timeframes where recovery is made?

Legal Implications

43. How does CMS define "group health plan" and "health care"
44. How is medical care defined?
45. What does applicable recovery claim mean?
46. How does this legislation balance against the Privacy Act of 1974 for Non-GHPs where consent from the beneficiary is not received?
47. Are we still liable to CMS for recovery payments after making good faith efforts to report settlement amounts to CMS?

48. Will reporting under the MMSEA require Non-GHP entities to pay the mistaken payments directly to the CMS Contractor? (*See 42 C.F.R. §411.22*)
49. Is there any circumstance where the Non-GHP entities can distribute the entire funds for a Settlement, Award, Judgment or other payment? If not, how are state rules and laws reconciled with regard to state court Satisfaction of Judgment procedures or obligations under State Fair Claims Administration Acts?
50. How will CMS recognize settlements where no liability is admitted?
51. How is the claimant & claimant attorney's held responsible for reporting identity information?
52. Will CMS require approval of every settlement with future medical benefits?
53. What is the process to ensure the insured reimburses Medicare for past/future claim payments from settlement/awards amounts?
54. What steps is Medicare taking to ensure the Non-GHP's liability is minimized in this scenario?
55. Will CMS want only total settlement amounts reported for Medicare/Medicaid eligible claimants or will they want to know what amounts were attributed to future medical costs?

OneBeacon Insurance Group ("OneBeacon") submits the following comments in response to the Supporting Statement For The MSP Mandatory Insurer Reporting Requirements Of Section 111 Of The Medicare, Medicaid, And SCHIP Extension Act of 2007 and attachments appended thereto.

Determination of Medicare Eligibility

Section 111(8)(A)(i) requires that an applicable plan "determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis..." A significant issue exists concerning the identification of claimants under the age of 65 who are Medicare eligible for reasons other than age. Given that the law imposes significant penalties for non-compliance, reporting entities are concerned that they must rely upon information provided by claimants themselves as the only means to avoid exposure to such penalties. Without additional guidance or assistance from CMS on this issue, reporting entities will implement manual claim processes in the form of interviews and/or written statements to make eligibility determinations for claimants under the age of 65. This is an imperfect solution that will undoubtedly result in Section 111 reporting deficiencies and cause delays in the claim process exposing reporting entities to potential liability under state unfair claim practices statutes. Additionally, reporting entities will flood CMS with reports involving ineligible claimants out of concern for being exposed to penalties for non-compliance. Further direction from CMS is requested to clarify what constitutes due diligence inquiry for purposes of compliance with this reporting mandate.

A more workable solution would be to provide reporting entities with query capability in the CMS database to make determinations of Medicare eligibility. This will ensure a more uniform approach to making eligibility determinations across all reporting entities and will result in more accurate reporting to CMS for Medicare eligible claimants under age 65.

Supporting Statement Comments

Collection Frequency

CMS indicates that reporting will be on no more than a quarterly basis and reporting of Non-GHP data will be on an on-going 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. Clarification is needed concerning the reporting frequency of no-fault and workers' compensation claims. Will quarterly reporting of such claims be required? Additionally, it is unclear whether CMS will be requiring reporting of payment information related to no-fault and workers' compensation claims for which there is an on-going reporting obligation.

Special Circumstances

CMS recommends a record retention period of 10 years. Does CMS intend to review closed records of reporting entities going back in time to before implementation of Section 111?

Burden Estimate

OneBeacon strongly refutes CMS' contention that collection of the required data elements will not cause undue burden on reporting entities. The premise that many of the data elements are required for internal business purposes is incorrect. Further, to the extent that reporting entities may already possess certain of the data elements does not mean that the collection, centralization, and reporting of this information is not unduly burdensome. OneBeacon further submits that CMS has greatly underestimated the labor costs associated with this reporting requirement both in terms of its estimate of reportable Non-GHP claims and its estimate of hourly labor rates.

Capital Costs

CMS states that there are no capital costs necessary to comply with Section 111 and bases this conclusion on the premise that all reporting entities will own at least one computer. This statement ignores the fact that for many reporting entities high volume reporting makes claim by claim data entry an impractical solution. Accordingly, many reporting entities will incur either significant capital costs in the form of internal IT expenditures or operating expenses for external vendor services, or both.

Attachment A – Definitions and Reporting Responsibilities

Many insurers required to report under Section 111 are organized as insurance groups with many subsidiary underwriting companies under a parent organization. Is the obligation to report and the registration/application process outlined in the Supporting Statement handled on the underwriting company level such that it will be necessary for an insurance group to register every underwriting entity issuing policies subject to reporting even if a particular entity retains no claim handling or administration functions?

Attachment D – NGHP Data Elements

Questions 12 through 15 seek information concerning claimants other than injured parties whose standing as claimants are based on death of an injured party. It is unclear whether multiple reports are necessary in situations involving multiple wrongful death beneficiaries. For example, a wrongful death claim involving a Medicare eligible decedent may be prosecuted by a person having legal standing to represent the decedent's estate on behalf of the decedent's spouse, children, parents, etc. In such a situation, what

should be reported in Question 12? Further clarification of the terms "beneficiary," "claimant" and "injured party" is needed.

Question 16 seeks Primary Plan insurance type. A single injured party may seek recovery under multiple coverages under the same policy (e.g., liability and no-fault). In such a situation it is unclear what insurance type should be entered in this field.

Questions 23 and 24 seek Primary Plan policy limit and policy limit exhaustion information for No-Fault claimants. While the definition of "No-Fault" appears to include simple "Medical Payments" coverages, more typical automobile "No-Fault" policies issued pursuant to state compulsory motor vehicle laws feature multiple coverages (e.g., medical benefits, death benefits, funeral benefits, wage loss benefits, etc.) with differing limits. More specificity is needed concerning the type of no-fault benefit for which CMS is seeking policy limit and exhaustion information.

Question 27 entitled "Self-Insurance" seeks a "yes" or "no" response. CMS has requested commentary on its proposal to require insurers to report in situations where an entity is "self-insured" for purposes of this section but pays its deductible to an insurer rather than directly to a claimant. OneBeacon supports this proposal to avoid duplicate reporting obligations.

Question 34 requests Date of Injury and indicates that, for exposure claims and ingestion claims, date of first exposure or ingestion is the date to be reported. In certain types of claims, the date of first exposure is outside of the policy coverage and would not coincide with the Date of Loss or Injury that is captured by reporting entities. Is it permissible for reporting entities to report this date based on their method of identifying loss dates (e.g. Date of Accident or Date of Loss)?

Question 37 requests "State of Venue." Clarification is needed concerning whether CMS is asking reporting entities to report the state where the accident occurred, the state where litigation is filed, the state where the claimant resides, etc.

Question 40 entitled "Product Liability" requests a "yes" or "no" response. Clarification is needed as to whether CMS seeks information on all product liability exposures (for example a defective toaster oven causing burn injuries) or only on those involving toxic tort or pharmaceutical product liability exposures.

Question 42 requests "Settlement Date" defined as date of settlement, judgment, award or other payment. More specificity is needed as to what date CMS is requesting. For example, a single claim may involve a judgment, settlement and payment all with different dates.

Question 44 requests information concerning claim resolution and provides the following four options:

- Contested, resolved claim with no on-going responsibility

- Contested, resolved claim with on-going responsibility
- Non-contested claim with on-going responsibility
- Non-contested claim, resolved with no on-going responsibility

These options are not self-explanatory and further clarification is needed concerning what information CMS is requesting with respect to claim disposition. The terms "contested" and "non-contested" as utilized in this context do not have clear meaning. Further, is CMS requesting payment information relative to no-fault and workers' compensation claims in the "Resolution" section?

Question 45 is entitled "Funding" and the parenthetical explanation asks "was funding of the settlement, judgment award or other payment contingent upon proof of resolution of Medicare's Secondary Payer recovery claim?" The meaning of this question is not clear and further clarification by CMS is needed.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Peachie.Pleasants@Carefirst.com
Sent: Tuesday, September 30, 2008 1:56 PM
To: CMS PL110-173SEC111-Comments
Subject: #148 [NGHP scope of applicability Q] question

Hello,

It appears that the main emphasis for Section 111 has been on Medicare Secondary Payer provisions. Can you please provide further clarity as to if the requirements for Section 111 refer to Liability Insurance, No-Fault and Workers' Compensation **Carriers** or do the requirements refer to anytime there is No-Fault, Workers' Comp or Liability situation?

Thanks in advance

Peachie Pleasants Williams
Senior Project Manager
Legislative Mandates
202-680-5342 (o)
202-680-7628 (f)

QUESTIONS

The 'Circumstances Under Which Insurers Must Report' Need Clarification

- Does section 111 apply only to claims filed after the October 1, 2009 date?

- If payments are still being made on claims with injury dates prior to October 1, 2009, are we expected to also report payments of medical made prior to October 1, 2009?

- In the Supporting Statement on page 6, Section 6 entitled "Collection Frequency" - While the requirement for No Fault and WC is to report on an ongoing basis, for non-contested claims there seems to be no requirement to include paid amounts from non-contested claims on an on-going basis. Attachment D, data element 43 'Amount' is apparently to be completed only if there is a settlement, judgment or award. Please confirm that there is no need to report paid benefits on non-contested claims.

- Are Medical Pay claims under homeowners and auto policies to be reported in addition to No Fault claims? A document on the CMS site on No Fault and liability insurance describes homeowners insurance under the definition of No Fault coverage. We had been under the impression that we were talking about statutory No Fault coverage and not Med Pay-type coverage available under homeowners policies. We also offer Med Pay coverage under our auto policies.

The Trigger of the Time Limits for Insurers to Report to the Secretary

- What is the meaning of "unresolved" in (8)(A)(i)?

- In workers compensation, settlements frequently do not become final until approved by the state workers compensation agency. Is the trigger the date the settlement is signed or the date it is approved by the agency?

- A similar question arises in the case of an award or judgment. Is it the date the award or judgment is initially made or when it becomes final? There are some state workers compensation laws that require the employer/insurer to pay during the time their appeal is pending with usually some mechanism for reimbursement should they prevail. Do those payments trigger the notification requirement?

- Will contested cases where there is a single settlement, judgment or award be required to report individually on the website or along with all other non-contested cases in the periodic report?

- Given the significant fines for failure to provide timely notice to the Secretary ($1,000 per day per claim on top of other existing penalties), can employers and

insurers provide notice prior to the triggering event? Will CMS have the necessary procedures in place?

- Is the notice requirement a one-time requirement or are we expected to notify the Secretary any time we make a medical payment? If the latter, this will be an extremely expensive obligation and will CMS have the capability to collect and use the information?

- If we made a payment and closed a file prior to October 1, 2009, will those be subject to the 10-year retention and will we be expected to be able to furnish those records?

Determining Whether a Claimant is "Medicare Entitled"

- What is meant by 'entitled to benefits under Medicare'?
  - Actually enrolled in Medicare Parts A and B?
  - Eligible to enroll in Medicare but has not done so; such as a person over age 65 that is still employed with group health benefits.
  - Has a reasonable expectation of becoming Medicare eligible within 30 months of an award, settlement, or payment?

- Is CMS planning to establish a website that will allow insurers to check whether a claimant is enrolled in Medicare? At present, this information is usually gathered by calling the local/regional CMS office and asking about the claimant and receiving a verbal response. Under S.2499, will we be safe relying on a verbal response? Because we are not an enforcement arm of CMS, could we rely on the response from the claimant or his attorney regarding the claimant's entitlement? We are troubled by the difference in language regarding information sharing by the Secretary between 7(C) and 8(G) of Section 111. Our concern is that CMS will argue that it need not share information with us regarding a claimant's Medicare entitlement status.

- Is the "suggested model form for the collection of Medicare beneficiary information" the same as the idea of a claimant form self-certifying their Medicare beneficiary status?

Allocation of Settlements

- Particularly in liability cases, there may be allocation by body part in settlements. Will CMS accept the settlement's allocation?

- In liability cases, will CMS accept the allocation of fault and its impact on damages or settlements?

Reporting Responsibility in Multiple Defendant Litigation

- In mass tort (asbestos and other toxic tort claims), it is very common that multiple insurers pay a share of one defendant's settlement (a common insured). Generally one insurer acts as the lead and the other insurers are non-leads. When settlement is reached that requires notification to CMS, are all insurers obligated to report the settlement or just the lead insurer?

- In a mass tort case where there may be dozens of defendants for each claimant's claim, it is common that each defendant pays a different settlement amount (some get dismissed without paying anything). For example, assume a claimant receives $500,000 in total settlements. One defendant could pay $1,000, another $25,000 and a third $150,000 towards the settlement. Assuming our insured defendant(s) pay(s) a share of the loss, how do we ensure we get proper credit so that we are protected against any later subrogation recovery action by CMS if one of the other insurers fails to report the settlement to CMS?

- It is not uncommon in a mass tort for a defendant and its insurers to do a group settlement. For example, a defendant settles for all 1,000 plaintiffs named in a toxic tort suit against multiple defendants where an insurer settles for one defendant. In such situations, the insurer may not know how the settlement funds will be distributed to the plaintiffs. That is, how much each claimant will receive or if each claimant will even receive any amount from that insurer's settlement. Thus the insurer may not know whether a Medicare eligible claimant has actually received any of the settlement money paid by them. How do we report such claims to CMS?

Data Submission Methods

- Does CMS want Liberty Mutual as a group to register on-line through the website and report data or apply and report on an individual market/division basis? We have multiple systems within Liberty Mutual.

- Will we receive an acknowledgement record from CMS that our data was received once submitted through the website?

- On page 9 of the Supporting Statement, the last paragraph notes that the non-GHP data elements in Attachment C will be electronically submitted. Please confirm that the applicable attached list of elements is actually intended to be D, which is titled "NGHP Data Elements."

- Please confirm that the reporting process will be by EDI (Electronic Data Interchange), not by manually typing the data into a web input screen.

- The last paragraph on page 9 of the Supporting Statement also mentions, "For Non-GHP entities reporting ongoing payment information..." How does that square with the issue of non-contested claims with ongoing payments - if we are to report ongoing payments, is there a data field for that in the data element list?

- For element 44 – Claim Resolution - will CMS assign values so that these situations can be coded?

- There are codes we use for Nature of Injury / Cause of Injury / Body Part that originate with either the WCIO or the NCCI. We are looking into how different the schemes might be, but would CMS allow both to be used?

Pertaining to Liability settlements:

- Where there is disputed liability and the case goes to trial and a jury verdict is awarded, whose responsibility is it at that point to determine CMS entitlement to future benefits especially in jurisdictions where the jury is not required to break down awards for past or future medical?

- Is a jury verdict on future medical considered acceptable protection of Medicare interests?

- Will plaintiff counsel have an obligation to secure Medicare's approval of the settlement before dispensing the funds?

Miscellaneous

- Why is CMS asking for Product Liability Information (element 41)? What does that information have to do with coordinating benefits?

- Will the reporting requirements of section 111 lead to a shift from the statutory requirements that all parties have an obligation to protect Medicare's interest to a CMS focus only on the obligation of payers?

COMMENTS

The 'Circumstances Under Which Insurers Must Report' Need Clarification

- We should not be expected to investigate Medicare entitlement unless, and until, the claim against our coverage involves a claim for payment of a medical expense related to the claimed injury or disease.

- Property/casualty insurers pay many claims with small amounts of medical. For example, 60-80 percent of workers compensation claims are for medical only. The latest available information on the countrywide average medical cost involved for those claims is $569. It is likely that it would cost more than $569 for the workers compensation insurer to investigate whether the claimant is Medicare entitled and for Medicare to collect, store, and use the information. Similarly, there are many automobile cases in which there may be a large property damage component but only a small medical component. There should be some de minimus limit established so that CMS is only notified of medical claims large enough to warrant CMS' collection effort.

- Regarding page 14 of the Supporting Statement, the first paragraph. In situations with high-deductible, large retention insureds, where they handle claims directly with their own system, and where the arrangement is insurance, not self-insurance, we are unsure what claim detail those clients pass to us, so that we as the responsible party would be able to pass on the information to CMS on a claim we will never touch. Provisions should be made for insured itself to report in these situations, as they do for WC Medicare setasides.

The Trigger of the Time Limits for Insurers to Report to the Secretary

- The payment, settlement or award should have to include payment for medical costs. The language fails to recognize the possibility of partial settlements such as payment or settlement to repair an automobile that leaves open the issue of payment of medical bills.

Determining Whether a Claimant is "Medicare Entitled"

- Depending on how "Medicare Entitled" is defined, it may be difficult and costly for insurers and self-insurers to obtain the necessary information to determine that a person is "Medicare Entitled" within the time limits set by state workers compensation, no-fault, or unfair claims settlement practice acts. For example, if the definition includes those that have a reasonable expectation of becoming Medicare eligible within 30 months, it means that an inquiry must be made to the Social Security Administration to determine whether there has been an application made by the claimant for SSDI or whether the claimant has filed for old-age benefits. Social Security charges for providing this information.

Allocation of Settlements

- In settlements including both workers compensation and liability, there is rarely any breakdown of the settlement into medical and other components. Therefore, if the Secretary asks for the medical dollars involved, the information does not exist. In the case of workers compensation Medicare set-asides, we have created artificial breakdowns so Medicare's interests could be taken into account. However, this has led to disputes with CMS' contractors over the amount to be set aside. Most settlements involve compromises because of disputes over liability, extent of injury, preexisting conditions, and other issues reflecting what accurately should be our policyholder's responsibility. As for liability, not all verdicts separately list damages for medical payments.

Reporting Responsibility in Multiple Defendant Litigation

- S.2499 does not address those claims or related claims that involve multiple defendants and does not establish a reporting priority. Situations involving multiple defendants include cases with diseases with multiple insurers on the coverage during the exposure period, joint ventures, risks with insurers having different layers of coverage, umbrella and excess, third-party workers compensation cases, impleader cases, actions over, etc.

PARHAM, WILLIAM N. (CMS/OSORA)

From: Blackaby, Dean [DBlackaby@mt.gov]
Sent: Tuesday, September 30, 2008 2:57 PM
To: CMS PL110-173SEC111-Comments
Cc: Braun, Kevin; Butler, Nancy
Subject: #151[NGHP - reporting requirements] Comments for Mandatory Insurer Reporting

Montana State Fund is a non-GHP entity providing workers' compensation insurance and is the largest insurer of employers in the State of Montana. Consequently, the processes involving the Mandatory Insurer Reporting program are of great concern and consequence. To that end, we have the following comments/questions during the initial comment period.

****

The Supporting Statement references GHP entities having quarterly reporting requirements but there is no similar reference for non-GHP providers. It simply states an "on-going" requirement exists for non-contested cases. **With what frequency are non-GHP entities expected to report**?

Concern exists regarding claims that extend over a significant period of time during which the claimant's Medicare status may change. **How frequently should non-GHP entities solicit information from claimants regarding Medicare status?**

It can reasonably be anticipated that the reporting requirement exists on any claim that is currently open or for which CMS has sought reimbursement of conditional payments it has made. However, there is no specific guidance in the Supporting Statement or other CMS material. The material does note that administrative offset is permitted for up to ten (10) years. There is also a seven (7) year statute of limitations for enforcement once a demand is made. **What is the specific requirement to solicit Medicare information from past claims which are still open? How far back?**

What is the anticipated timing of CMS release of: (1) User Guides for submission of data; and (2) suggested model form for the collection of Medicare beneficiary information?

Contact Information:

Kevin Braun 406.444.6423 / kbraun@montanastatefund.com
Dean Blackaby 406.444.6574 / dblackaby@montanastatefund.com

Special Assistant Attorney Generals
Montana State Fund
P.O. Box 4759
Helena, Montana 59604

ARCHER & GREINER, P.C.
ATTORNEYS AT LAW

SUSAN S. HODGES
Also Member of Pennsylvania Bar

ONE CENTENNIAL SQUARE
HADDONFIELD, NJ 08033-0968
856-795-2121
FAX 856-795-0574

www.archerlaw.com

Email Address:
shodges@archerlaw.com

Direct Dial:
(856) 354-3076

September 30, 2008

E-mailed to:
PL110-173SEC111-comments@cms.hhs.gov

RE: Comment-
Medicare Secondary Payer Mandatory Reporting Requirements - Section 111

Dear Sir/Madam:

This office represents the New Jersey School Boards Association Insurance Group (the "Group"). We are writing this comment on behalf of the Group in response to the recent mandatory insurer reporting requirements of Section 111 of the Medicare Medicaid, and SCHIP Extension Act of 2007.

By way of background, the Group is a not for profit association, organized as authorized by N.J.S.A. 18:A:18B-1, et. seq., and its implementing regulations. The Group is not an insurance company or an insurer under New Jersey law. N.J.S.A. 18A:18B-3(d). The Group administers a joint self-insurance fund, which is a fund of public moneys from contributions made by members of the Group, including for the purpose of securing insurance protection, risk management programs and related services. See N.J.S.A. 18A:18B-1(a), (b) & (c). Pursuant to N.J.S.A. 18A:18B-1 et seq., the Group provides insurance, including workers compensation insurance, to its members, multiple public schools across the state of New Jersey.

If applied to the Group, these reporting requirements will add an additional cost that will ultimately be passed on to the taxpayers of the State of New Jersey. These reporting requirements will also place a great administrative burden on the Group when, in fact, the information to be reported is in the hands of a third party, who should have their own reporting obligations. Please clarify if these regulations apply to not for profit organizations such as the Group.

Additionally, the Group would like further clarification provided on the definition of the following terms: "Contested Claim," (as indicated for the four types of claims resolution), "Settlement Date," (where there are three examples listed each of which could have a different date), "Exhaust Information," "Injured Party," "Claimant," "Beneficiary," and "Situational."

Finally, is there a penalty assessed when this information is requested of the plaintiff/claimant or their attorney, but it is not provided to the entity required to report it? Since much of the information requested is held by the plaintiff/claimant and their attorney, they should be responsible for providing same, or responsible for the penalty.

Thank you for your consideration of these comments. We look forward to your response.

Very truly yours,

SUSAN S. HODGES

SSH/tg

cc: Louis Giannetto
Marty Kalbach, Director

3582225v1