PARHAM, WILLIAM N. (CMS/OSORA)

From: CMS PL110-173SEC111-Comments
Sent: Wednesday, October 01, 2008 11:36 AM
To: PARHAM, WILLIAM N. (CMS/OSORA)
Subject: FW: #132 [mulitple questions] Section 111 comments
Attachments: Comments.doc

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

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.

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NuQuest Bridge Pointe

One Source for Medicare Secondary Payer Compliance

September 29, 2008

The Centers for Medicare & Medicaid Services (CMS)
Office of Strategic Operations & Regulatory Affairs
Division of Regulations Development

Submitted to: http://www.regulations.gov/fdmspublic/component/main?main=SubmitComment &o= 09000064806a5f63

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

RE: **Submitted "Comments" Per CMS' "Supporting Statement" for Reporting Responsibilities Under Section 111 of the MMSEA**

Dear Sir/Madam:

Please accept the following 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.

The following is also being submitted in relation to CMS' "Open Forum" teleconference call being held on October 1, 2008.

The undersigned hereby respectfully requests that CMS address the following:

Determining Claimant's "Entitled" to Medicare

Pursuant to Section 111 (a)(8)(A)(i) of the MMSEA, applicable plans are required to *"determine whether a claimant (including an individual whose claim is unresolved) is **entitled to benefits** under the program under this title on any basis."* (Emphasis added).

Per this section, clarification is requested as follows:

1. Define what is meant by "entitled to benefits" in terms of the Section 111 requirements.

2. For purposes of the Section 111 requirements, is there a distinction between the concepts of one being "entitled" versus "eligible" for Medicare benefits?

Furthermore, Section 111 does not contain any provisions requiring the claimant to execute an authorization permitting the applicable plan to obtain a claimant's Medicare entitled status from the Social Security Administration (SSA) or other governmental entity. Likewise, no such direct provisions are contained under the Medicare Secondary Payer Statute or Code of Federal Regulations. Accordingly, please advise as to the following:

1. Any statutory or regulatory authority known to CMS which would require claimants to execute authorizations allowing primary payers or other interested parties to obtain a claimant's Medicare entitlement status directly from the SSA or other governmental entity.

2. In terms of an applicable plan's obligation to determine if a claimant is "entitled to Medicare" under Section 111, what is CMS' required or recommended manner of proof? Will utilization of such proof methods protect applicable plans from liability under Section 111?

3. Will CMS be issuing a regulation or other mandate (a) requiring claimants to execute authorizations allowing primary payers to obtain official Medicare entitlement status from the SSA or other designated entity and/or (b) requiring claimant cooperation in terms obtaining the required information to determine if he/she is "entitled to Medicare" under the applicable provisions of Section 111.

Collection Frequency (Supporting Statement, Section 6 at p. 6)

With regard to "Non-GHP" data, the following is indicated:

Non-GHP data will be 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.

In relation to the above cited proposal, please address the following:

1. Define the terms "non-contested" claim and a "contested" claim.

   In addressing this question, the undersigned wishes to point out that often times a particular claim contains both "non-contested" *and* "contested" aspects. For example, a primary payer may accept responsibility for one body part (which would seemingly constitute a "non-contested" aspect of the overall claim) but deny responsibility for another alleged body part (which would seemingly constitute a "contested" aspect of the overall claim).

2. With respect to "non-contested" claims, please define the phrase "*on an ongoing basis.*" In relation thereto, please advise as to the specific event(s) which would give rise to the obligation to report a claimant's Medicare status.

3. Section 111 of the MMSEA [42 U.S.C. 1395(b)8(C)] states as follows:

   (C) Timing – Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability). (Emphasis added).

   A literal reading of this statutory section would seemingly indicate that the obligation of an applicable plan to place Medicare on notice would not be required until *"after"* the claim is *"resolved"* through one or more of the cited events. However, CMS' proposed guidelines regarding "non-contested" claims as contained in the Collection Frequency section (cited above) speak in terms of an "ongoing basis" *without* specific reference or direct correlation to the specific events listed in the aforementioned statutory provision.

   Thus, does CMS' proposed guidelines regarding "non-contested" claims contemplate that an applicable plan will be required to place Medicare on notice regardless of whether or not a claim is "resolved" per 42 U.S.C. 1395(b)8(C)? In this regard, what is meant by the phrase *"on an on-going basis"*?

4. With respect to "contested" claims, please define the phrase "*other payment.*"

Non-GHP RRE Reporting (Page 13-15)

Is a "responsible reporting entity" (RRE) permitted to use more than one agent for purposes of reporting under Section 111?

By way of background, it is common in the industry for larger insurers and self-insureds to utilize more than one TPA for claims handling and administration. In keeping with this model, under the Section 111 requirements are RREs permitted to use more than one agent for reporting purposes under Section 111?

Attachment D – NGHP Data Elements (Supporting Statement, p. 18-20)

Data Element 10 (SSN) & Data Element 11 (HICN), p. 18

According to the data elements table, the RRE must report either the claimant's SSN or HICN.

Consider a situation where a RRE places CMS on notice prior to a claimant being entitled to Medicare. By way of example, assume that the RRE places CMS on notice by using only the claimant's social security number. Assume further that per this reporting it is determined by CMS that the claimant is *not* actually entitled to Medicare at that time. From this factual scenario, the following questions are presented:

1. If it is determined that the claimant is not in fact entitled to Medicare at the time the RRE reports, what happens to said notice from a filing standpoint? That is, will CMS discard or purge the information and notice from CMS' system?

2. If the claimant were to become entitled to Medicare at some point *after* said reporting, would such prior notice and reporting be effective in regard to the Section 111 reporting requirements or would the RRR need to submit a new notice?

Data Element 15 (TIN, SSN or EIN), p. 18:

Does the requested TIN, SSN or EIN relate to the deceased beneficiary or the "claimant" (the successor party in right) filing the action on his or her behalf?

Title to Data Elements 16-24, p. 18-19:

The section title pertaining to data elements 16-24 is stated as follows:

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

The undersigned requests clarification as to the meaning and intent of this section title . Furthermore, clarification is requested regarding the reference to settlements involving *"more than two individuals"* and the corresponding requirement to report "separately" in relation thereto.

Data Element 17 (Name) & Data Element 18 (Address), p. 18

Does the request for the "name" and "address" pertain to the insurance carrier or self insured or some other entity or person?

Data Element 19 (SSN), p. 18

Please explain the relevance of the "SSN" in relation to this section. Assuming that through this section the information sought pertains to a carrier, self-insured or other entity other than the claimant, please advise the relevance and relation to the "SSN."

Data Element 21 (Policy Number), p. 18

It is indicated the "Policy Number" is a mandatory data element. In relation thereto, the undersigned poses the following questions:

1. The basis for this information under the statutory provisions of Section 111, and from a more practical standpoint, the relevance of this information from an administrative standpoint in relation to CMS' implementation of the Section 111 requirements.

2. The purpose of this information being coded as "mandatory."

Data Element 35 (Nature of Injury) & Data Element 36 (Cause of Injury), p. 19

It indicated that the 'Nature of Injury" and "Cause of Injury" are "situational" element fields. In relation thereto, the undersigned poses the following questions:

1. Under what circumstances or factual scenarios do these element fields become operative?

2. The underlying rationale and basis for ascribing these fields "situational" status.

Data Element 38 (ICD-9 Code) & Data Element 39 (Body Part), p. 19

It is indicated that these data fields are "situational." In relation thereto, the undersigned posed the following questions:

1. Under what circumstances or factual scenarios do these element fields become operative?

2. The underlying rationale and basis ascribing these fields "situational" status.

Definition of "contested" claim under the "Resolution" section, p. 19

Under the "Resolution" title the following phrase is indicated:

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

Please define the term "contested claim" as contemplated in this context.

Data Element 42 (Settlement Date), Data Element 43 (Amount) & Data Element 45 (Funding), p. 20

These data elements are contained under the section entitled "Resolution." The listed data elements under this section are preceded by the following phrase:

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

Per a literal interpretation of this phrase, it would appear that in the context of a settlement of a *"non-contested"* claim, the *date of the settlement, judgment or award; amount of the settlement judgment, or award;* and *funding* (data fields 42, 43 and 45, respectively) would NOT need to be reported.

Accordingly, the undersigned hereby poses the following questions:

1. Under the current provisions of the MSP and CMS practice, advisement of a final settlement, judgment or award (regardless "contested" or "non-contested" status) and the forwarding of information in connection therewith (such as the amount thereof) are required in terms of establishing a primary payer's obligation to reimburse Medicare for conditional payments, calculation of procurement costs, and determining the ultimate amount of CMS' recovery.

   In light thereof, please advise if it is in fact CMS' intention that the information contained in data element fields 42, 43 and 45 does NOT need to be reported in relation to non-contested claims. If this is CMS' intent, please advise as to the (a) rationale and basis of this policy, (b) when under the MSP a primary payers obligation to reimburse Medicare in the context of non-contested claims ripens and the process a primary payer should follow to notify CMS accordingly, and (c) how CMS proposes that primary payers provide it with the information and documentation necessary to determine the establishment of CMS' right to reimbursement, calculate the amount of procurement costs, and determine CMS' recovery amount.

Data Element 44 (Claim Resolution), p. 20:

Please define the concepts listed under this section and provide examples of what is meant or contemplated by CMS with respect to each. The listed concepts are as follows:

- 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.

Data Element 45 (Funding), p. 20:

Under the "Funding" section the following phrase is indicated:

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.

The undersigned requests that CMS provide clarification of this phrase and CMS' intent in relation thereto. In this regard, the undersigned would note that "resolution" of a Medicare conditional payment claim would only be possible *after* the underlying claim was resolved as under current practice the "final" amount of claimed conditional payments cannot be obtained until the settlement is finalized and forwarded to CMS. It is not until that time that CMS will provide its "final" conditional payment made in the context of its issuance of its "final demand" for conditional payments which includes a specific time period for actual payment.

CONCLUSION

If there are any questions regarding the above, please not hesitate to contact the undersigned at 786-457-4393 or mpopolizio@nqbp.com

Thank you for your courtesy and consideration.

Respectfully Submitted,

Mark Popolizio, J.D.
Vice President of Customer Relations
NuQuest/Bridge Pointe
786-457-4393
mpopolizio@nqbp.com

PARHAM, WILLIAM N. (CMS/OSORA)

From: CMS PL110-173SEC111-Comments
Sent: Tuesday, September 30, 2008 2:13 PM
To: PARHAM, WILLIAM N. (CMS/OSORA)
Subject: FW: ACE's comments & questions related to MSP legislation
Attachments: Questions and Commentary Related to MSP regulations 9-29-2008.doc

Follow Up Flag: Follow up
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Categories: Red Category

Once again labeled with the 10265 but cannot tell if you received them

>-----Original Message-----
>From: Kennedy, Thomas P [mailto:Thomas.Kennedy@ace-ina.com]
>Sent: Tuesday, September 30, 2008 1:37 PM
>To: CMS PL110-173SEC111-Comments
>Cc: Henry, Patricia A
>Subject: ACE's comments & questions related to MSP legislation
>
>Attached is ACE USA's comments regarding 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)
>
>Thank you
>Tom Kennedy
>AVP, Operations
>ACE USA
>436 Walnut St
>Philadelphia, PA 19106
>215.640.4052 (w)
>215.796.3951 (m)
>
>_____

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?

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.

NAWE

National Association of Waterfront Employers

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September 29, 2008

The Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C-4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS 1026-Information Collection Request
Federal Register, August 1, 2008; Request for Comments

Dear Sir/Madam:

These comments are provided by the National Association of Waterfront Employers (NAWE) addressing the reporting requirements mandated by recent changes in the Medicare law in 2007. NAWE represents marine terminal operators who load and unload vessels calling on U.S. ports. Reporting for workers' compensation, no-fault and liability data is to be effective on July 1, 2009. Group health is to be effective on January 1, 2009.

While we are aware of the need to identify beneficiaries for whom Medicare is the secondary payer, we believe that the enormity of this undertaking may not be well appreciated by CMS. In our opinion, the time tables are not realistic, and our first suggestion is to delay the implementation of all data collection for at least 6 to 12 months.

According to the Bureau of Labor statistics, there were over four million workers' compensation claims in 2006. Most will not meet the reporting guideline, but there is a significant cost to review these claims. The hiring of additional employees or a third party to compile the data will be required, and the ultimate cost to the government to implement this program is greatly underestimated. The additional cost to employers and the taxpayer will exceed the estimate by millions of dollars. Using the group health data to estimate the costs and complexity does not yield valid comparisons. Workers' compensation, automobile no-fault and liability claims are substantially more complex than group health claims.

Workers' compensation coverage for maritime workers is provided under the Longshore & Harbor Workers' Compensation Act (LHWCA). This is the federal program that is administered by the U.S. Department of Labor (DOL). Other workers are covered under state administered programs. LHWCA payments are sometimes made under both a state administered program and the federal program. These payments are provided under a

mix of insurance, and self insurance, all regulated by DOL. The number of reporting entities for longshore affected by this reporting requirement exceeds 500.

Our second suggestion is that the information that you require for LHWC claims is already given to DOL on all open cases and has been done since 2005. All insurance carriers or self insured employers must file annually with DOL information that requires the claimant's name, social security number, date of injury, nature of injury, estimate of future medical payments and other relevant information. It appears to us that the information that we already submit to DOL could be used to satisfy some of our reporting requirements.

Another complicating factor is concurrent jurisdiction. A terminal operator is liable under both state workers' compensation laws and the federal Longshore Act because of the issue of "concurrent jurisdiction in the states of California, Connecticut, Georgia, Massachusetts, New York, South Carolina, and Virginia. Will two reports be required for these claims?

In regard to group health claims we operate as a multi-employer hiring hall industry. The bargaining agent administers our contract and pays benefits for group health claims under the union agreement. The employer only has records of management employees covered by the employer controlled plan. Who reports the group health data in this situation?

Marine terminal operators pose unique issues that we believe should be considered in the development of these reporting requirements. NAWE hopes that we can have the opportunity to meet with CMS to discuss these matters.

Lastly, we endorse the comments made by UWC as representative of issues that are common to all employers. Those comments highlight the very practical difficulties of implementing a program of significant data reporting in a very short period of time.

We remain committed to assisting CMS in the implementing of these new data requirements, but want to do so in a way that makes sense.

Sincerely,

Charles T. Carroll, Jr.
Executive Director

America's Health Insurance Plans

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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

Zurich North American Insurance Comments in Response to the CMS Document Entitled: Supporting Statement for the Medicare Secondary Payer—published 8/01/08 on the CMS Website

1. In Section 13, CMS alleges that there will be no capital costs to comply with the SCHIP reporting requirements. Our initial estimate to make changes to our current computer system to ensure reporting compliance is very substantial. The employees or contractors who we will need to engage in programming the system make substantially more than $12 per hour.

2. In Section 12, CMS estimates that it will take only 5 minutes for an employee making $12/hr to collect social security numbers. Based on the public's being advised to never give out your social security number, we believe that the 5 minute estimate is too optimistic. Further, with benefits and wages, our administrative support employees' average pay is significantly higher than $12/hour.

3. There are 45 proposed "data fields" listed in Attachment D which are either "Mandatory, Situational or Optional". If situational applies, does it now become a "Mandatory" reporting requirement? What is the definition of "situational"?

4. Is the only way to ensure compliance with the reporting requirements and avoid the $1000/day fine, to notify CMS of all Workers Compensation, No Fault and Liability claims? Is CMS prepared to handle the data submission of almost every Workers Compensation, No Fault and Liability claim being made countrywide? Please note that our pending of all open, existing claims for the applicable lines of business is in excess of 1,000,000.

5. On cases involving exposure to harmful contaminants, there are often multiple carriers making payment to the same claimant. If all carriers must report their portion of the settlement, do they put in Data Field #43, the amount of their contribution, or the full amount of settlement?

6. If Zurich writes business under several trade names, all under the Zurich umbrella, must separate reports be provided for each name or can they all be combined?

7. What is the trigger for when the claim must be reported? Is it only when a payment is made?

8. If an injured claimant has both a liability claim and a med pay claim, must both be reported?

9. Must the same claim be reported every quarter, as long as it remains open, or does it only need to be reported once? And, if the claim has to be reported each quarter but a carrier inadvertently misses one quarter, will it still be subject to a fine even though it has satisfied the reporting requirement in the other quarters?

10. When will additional "listening sessions" be scheduled?

11. For data field #19 "TIN", is that the TIN for the policyholder or for the insurance company?

12. The ICD 9 code, data field #38 is not currently collected on Liability and No Fault claims. In workers compensation, there may be multiple ICD9 codes on various medical bills. Which code are you asking for? Will the body part code suffice for Workers Compensation? If so, our system is set up to report one code only and not multiple codes. Will one code be enough? If the body part is reported under data field #38, what must be reported under data field #39? What is required with respect to Liability claims, where the ICD9 code is not currently collected?

13. For data field #44, if we are reporting an open claim which has not yet been resolved, what must be completed in that data field?

14. For liability claims, there are situations where the claimant will not provide their social security number. They are not required by law to provide their social security number to file and pursue a claim. If we are not able to obtain their social security number, what information would suffice, if any, for reporting purposes to Medicare?

15. Please note that some of the data fields you have listed are not currently collected as part of our routine claim handling. Those fields include:
Data field #19 – TIN of insured
Data field # 38 for liability and no fault claims
Data field #41 – product liability information
Data field #44 – claim resolution
Data field #45 – Funding

16. For data field #9, Gender, our claim system has an "unknown" code as well as "M and "F". Will the "unknown" code be accepted?

17. For claims involving exposure, what if the state law imposes liability on the date of last exposure, not the date of first exposure, so that carriers typically use the date of last exposure for the date of injury? Shouldn't the injury date vary depending upon what date the jurisdiction uses as workers' compensation carriers in Pennsylvania, for example, which goes by date of last exposure, will have no ability to easily locate and provide the date of first exposure?

18. Regarding the data element that requires that we identify the "product" in a products liability claim, please note that most product liability claims are caused by machines, manufactured products, etc. and not by prescription medications. We do not currently have a data field in our claim system that identifies the product which can be easily transmitted via EDI. A data field would have to be added and built into our claim system.

19. In fatality claims, the name of the claimant that is entered into our system is the decedent and not the widow or children. There are currently no data fields in which to enter the widow's and children's' names. Such data fields, if required, would have to be added and built into our claim system. Please note that in a death case, only one claim is established for all dependents. There are not individual claims established for each dependent. To establish additional claim numbers would impact our customer's frequency and loss ratios, resulting in an unnecessary negative premium impact.

20. Will the SSA form "Consent to Release" (OMB #0960-0566) still be required to verify social security and Medicare status of an injured worker or third party claimant? Is there a violation of privacy laws if the signed release is no longer required?