TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b)(7)

DATE OF CALL: March 18, 2010

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

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: John Albert
March 18, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is Melissa and I will be your conference operator today. At this time I would like to welcome everyone to The MM-SEA-111-THT Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mr. John Albert with Centers for Medicare & Medicaid Services, you may begin your conference call.

John Albert: Thank you operator and good morning or good afternoon, depending on where you're calling from. This is one of the continuing series of open-door teleconference events CMS is hosting as part of its implementation of the group health plan reporting requirements under Section 1-11 of the Medicare & Medicaid Ship Extension Act of 2007.

Again, this call is geared toward group health plan reporting obligation. We have other calls that we scheduled for workers comp liability no faults, ensure reporting – some of you are part of that group, you don't need to be on this call, because again this is towards – geared toward group health plan reporting requirements.

Just real quick, there's a – we're fairly light in staff here today, but we'll hopefully will be able to still answer all of your questions. Some people will be joining us late, so for example once we get through the presentation that Pat Ambrose will do as she always does on these calls and we get into the open-door – the open Q&A session, if there are any questions regarding

HRAs, we would ask you to hold those until later in the call as Mr. Bill Decker is attending another meeting that he has to be in right now, and he has been working on those issues primarily for CMS.

I also have to state the qualifier that occasionally we do speak regarding contradicting information that is either in the user guides that we have published on the website or regarding other certain regulations laws that the CMS operates under. If that's the case you know, again, the written material always takes priority over what we say on the call just in case we do you know, say something incorrectly.

Other than that we can jump right in to it, the group health plan reporters have all been on-going for a long time now. And we have close to 800 plans or IDs reporting information to CMS right now and we appreciate the work that everyone is doing. We are looking at that data, again as this process moves forward, you'll be receiving more and more feedback from CMS to help you improve the quality of the data we are already seeing you know, particular issues that we're trying to figure out how to handle and we will be getting back to folks on that as we already have on a case by case basis.

But with that I'll turn it over to Pat and we'll jump right in.

Pat Ambrose: OK. Thanks, John. First, some general announcements. On the last call I talked about formatting address lines and in particular trying to segregate the street number and street name from other miscellaneous address information such as the suite number and attention to and that sort of thing.

It was brought to my attention by someone submitting an email to the Section 1-11 CMS resource email box that I've misspoke and so I did go back and revalidate this requirement about addresses, it actually is more an address standard that we ask that you would hear to right now the system has not been changed to create an error in the event that we don't get an address formatted properly or formatted in this way. So the actual requirement is that the street number and street name be segregated on a separate address line from the rest of the information.

I had stated that the street number and street name must go in line 1 and the other information in line two and actually U.S. Postal Service standard – are actually saying the opposite that extraneous information should go first and the street number and street name should go closest to the city, the line in which the city goes, so that would be in address line two.

However, we're a little bit more flexible than that and ask that when you're formatting address fields that you put the street number and street name in a separate address line and in the other address line put the other information like suite number, apartment number, attention to and mail routing and that sort of thing.

The next announcement has to do with the computer-based training modules of we're about to release updated CBTs based on Version 3 of the GHP user guide – so stay tuned for that – you will, if have registered already for the computer-based training, you will be automatically notified when these updates are available and if you have not registered you may do so on the CMS Section 1-11 website, that's www.cms.hhs.gov/mandatoryinsrep and in the left hand menu you'll see an option for finding up for the computer-based training modules or CBTs.

We have some questions on the last call about specific Medicare health insurance claim numbers HICN or I pronounce it HICN very often in the – the particular issue that was raised was HIC Numbers or HICNs that began with the characters H-zero and this caused a problem when submitting the HIC number on the MSP Detail Record and the HEW query, the HEW HIPAA Eligibility Wrapper Software Query Record.

The software was presuming that the H0 was actually had a record when actually the intent was that – it was a detailed record, but happened to have a HIC number in that first position starting in that first position of the record with the characters H0.

It turns out that for certain railroad board beneficiaries who are Medicare beneficiaries some of them at one time were assigned HIC Numbers or Medicare health insurance claim numbers that began with the characters H0,

so we went back and do the check on this and found that all such individuals have long since been deceased.

So there is no living Medicare beneficiary with a HIC number beginning with H0 on our Medicare database, so it should not be necessary for you to submit any GHP coverage for them nor to query that individual's Medicare status. If for some reason you only have a HIC number for an individual that begins with H0 in order to query them to get the proper HIC number, you will have to obtain the Social Security number and query with the Social Security number, but I'm quite confident we did do a search on the database and there are no living Medicare beneficiaries with the HIC number beginning with H0. So you should not need to report those individual on your MSP input file.

So and I've also been told that that HIC number ranged beginning with the characters H0 will not be reused in the future so we don't think that we need to make any changes to accept HIC number beginning with those characters.

Next, I'd like to remind you to please review Section 12.2 of the GHP user guide regarding contact with your EDI representative and the appropriate escalation procedures to the EDI Department supervisor and then to the EDI Department manager and finally to the COBC project director as needed. Your escalation will help us track those issues that are our ease are not getting resolved in a timely fashion and we appreciate your following that escalation process, sometimes we see folks that are submitting their issues to the section 1-11 CMS email address and well that is OK, it's not really the best way to get your issue addressed in a timely fashion and escalate it appropriately

John Albert: Especially technical issues.

Pat Ambrose: Yes, exactly.

So as we covered previously on these calls, but then again as reminders, you must process your response file that you received back for Section 1-11 reporting of your MSP input file, you must process that MSP response file as detailed in the GHP user guide. It contains critical information regarding your Section 1-11 submission, process that response file from the last quarter first before sending your next quarterly submission, even if that means that your

next quarterly file submission maybe late. CMS would rather have it done correctly than submitted it on time, but without the proper processing.

Now that said, if you're going to be late with your quarterly file submission, you should notify your EDI representative. Please only submit delete records in the case where the record was previously accepted with the 01 or an O1 disposition code there's no need to delete a record that was sent, but not accepted and in fact will be returned with an error, remember that you are not to delete a record when an individual's GHP coverage ends, send an update with the termination date.

Also, if you receive a response file back or the majority – either all of the records were rejected or the majority – a very high percentage of the records were rejected for example, you didn't submit a TIN reference file record necessary or something of that nature, you need to contact your EDI representative immediately, most likely they will be following up with you as well, but we do want to fix this kind of serious file errors as quickly as possible. We don't want you to wait until the next quarterly file to fix this serious problem such as this. So please work with your EDI representative in those – under those circumstances.

And lastly, and really most importantly if you mistakenly included retirees on your MSP input file, people for whom Medicare is not secondary and you have received back O1 disposition codes for those individuals indicating that the COBC has created MSP occurrences, meaning that the GHP is to pay primary and Medicare secondary, but that is not the case, for example with retirees who are not covered by active employment, please do not wait until your next file submission to correct that.

Contact your EDI representative immediately to discuss the situation, in some cases you will be asked to send a file of delete transaction to remove those erroneously created MSP occurrences right away. It really depends on the circumstances, the number of retirees that you may have sent incorrectly and so on, but please contact you EDI representative immediately, because we all know what happens in those circumstances – a Medicare beneficiary will – Medicare will start denying their claims for primary payment and obviously

that causes a lot of confusion and consternation and that's the last thing that we want to happen out of this process. We're looking to get claims paid by the right entity in the right order the first time through.

Did you have something to add to that?

John Albert: No, I mean that's the important, because again it just ends up you know, clogging up your phone system and our phone systems trying to correct this information and obviously you know, the last thing we want to do is you know some kind of unintended negative impact on our beneficiaries and the sooner the better, because again these are claims payment issues and these are pending issues so-.

Pat Ambrose: OK. I'm going to go into trying to answer some of the questions that were submitted to the Section 1-11 email box and provide again some answers to the ones that I'm able to.

The first question had to do with the calculation and the submission of employer size. So, please make sure that you reviewed the new Appendix I on Employer Size and Employer Size Reporting in Version 3 of the user guide. This question in particular asked, when submitting employee accounts for the disabled provision, should the count be submitted in the manner to show how coordination of benefit would be updated or should it be sent as true information?

For example in 2008, an employer has 90 employees and in 2009, 110 so in 2008 the employer was under the100 employee threshold and in 2009 they were over that threshold. Now I'm assuming for the purposes of this question that that was for more than 50 percent of the employer's business days in that – those years. So the questioner is asking, then should they submit employer size on their – on the GHP coverage records on their MSP input file.

So employer size should be reported as it pertains to MSP. So coverage in 2010 should be reported with an employer size that reflects the number of employees in prior or current calendar year depending on the MSP provision, not the number of employees the employer actually had during the exact month of the GHP coverage, so in the example given, supposed the employer

had 90 employees for all of 2008 and 110 employees for all of 2009. The employer size reported on GHP coverage record for 2009 will reflect the actual count during 2008 or 20-99 employees or an employer size value of one on the MSP input file record.

The employer size reported for GHP coverage in 2010 would reflect the actual count in 2009 which is more than 100 or an employer size value of two. The rules about 20 employees – the 20 employee threshold require the RRE – look not only at the last calendar year, but also the current calendar year having less than 20 employees for 20 weeks or more in the last or current calendar year. So again please review in detail the user guide Appendix I and we also are releasing a CBT on employer size that I think would be extremely helpful, so it's not just simply reporting the number of employees during the period of time of the GHP coverage, but rather the employer size that relates to the MSP conditions or regulation during that time period. So, hopefully I've provided some clarification there, I'm sorry it's so complicated, but those are the MSP regulation.

John Albert: I did not write them.

Pat Ambrose: Thank you. OK, the next question had to do as to whether Section 1-11 mandatory reporting requirements are applicable to U.S. territories and Puerto Rico? And the answer to that question is yes, if the Medicare beneficiary is an active covered individual receiving benefits under employer's sponsored GHP and so on if those reporting requirements are met reporting under the GHP mandatory reporting requirement of Section 1-11 is necessary and those requirements have been met.

The next question goes on to ask about the RRE DCN or Document Control Number Field that were added to the query only input file and returned on the query response file. This particular person was asking if in addition to those RRE DCN fields we could also add another field on that this particular RRE wanted to use for employer group size and that they would actually submit this under input record and we would in turn just return that.

Now, first I want to say that CMS and the COBC do not have information on employer size that's up to the RRE to get that information from employers or other plan sponsors as necessary and also, there are two RRE DCN fields on the query input and response file. So this particular request could be satisfied by the RRE using one DCN field for an actual document control number so they can match input records to output records and they could use the other field RRE DCN field for whatever purposes they wanted.

You can put any alphanumeric characters in there and exactly that information will be returned back to you. We did have – speaking of DCN, we did have an issue in the system with these RRE DCN fields where the system was erroneously removing embedded spaces, so someone might have put something in the DCN field that was AA space 1-2 and the system was returning AA-1-2 without that embedded space. That has been corrected and the system is no longer removing those embedded spaces so again, whatever you put in those RRE DCN fields, you should be receiving back on the response file that's returned to you.

Another question was submitted related to Accident and Health due to past definition these RRE's started reporting some Accident and Health products under the GHP reporting process, because it appeared that they met the GHP definition in the new GHP user guide we have – for non-GHP we have indicated that Accident and Health products are actually reportable as no fault under the non-GHPD liability no fault and worker's compensation reporting for Section 1-11. So if you reported Accident and Health products under GHP and those products do not set the definition of an employer's sponsored group health plan and should not be reported under GHP Section 1-11 then, for any of the records that you submitted and got an O1 disposition code, such that indicating that the COBC created an MSP occurrence, you should submit delete records to remove any such MSP occurrences that were erroneously created since they will have been posted out there with an incorrect MSP type and then look to reporting this coverage as specified under non-GHP reporting for Section 111.

The next few questions have to do with Social Security number. One question was asking what alternatives an employee can provide if they or their

dependent either does not have an SSN or does not want to provide an SSN. Another question was asked whether CMS could please clarify what the requirements are around an employee who refuses to provide a Social Security number. What is the RRE's liability in this circumstance and the last question is related in a sense to those. This RRE is reporting that they had not in the past tracked dependent Social Security numbers or collected information for dependents that is necessary to report for Section 111.

Again, remember that we accept either of the Social Security number or we would prefer that you obtain the Medicare health insurance claim number, the HIC number instead, but at any rate this RRE is indicating that they don't have that information for dependents and they're asking is it better to submit dependent records without the SSN or HICN or, you know, take some other alternative.

First, let me – to address all of these questions, please make sure that you've reviewed the alert regarding the HIC number and SSN collection and the model language that are out on the Section 111 website. One is dated August 18, 2009 and the other is dated May 26, 2009, and both are on the What's New Page. These documents are specific to GHP RREs.

Also, please review the definition of an active covered individual in the user guide. Not every dependent must be queried and reported, only you active covered individual. So, please review that definition and as we've stated on previous call, if an individual does not have a Social Security number because they are foreign national or, you know, not a US citizen, they are not a Medicare beneficiary and do not have to be reported.

Those alerts, however, will provide you information on what the RRE's responsibility is in terms of a situation where you cannot obtain the HIC number or the SSN to query in or report on an individual. And lastly, if you don't have the SSN or HIC number, it does no good to send a query or an MSP input file record without an SSN or HIC number.

John Albert: One or the other.

Pat Ambrose: You must submit one or the other.

You must get one or the other – the HIC number or the SSN for active covered individuals in order to query and/or report on the MSP input file. Basically, if you fail to report Medicare beneficiaries that active covered individuals on your MSP input file, you are not incompliance with Section 111 reporting requirements, sending in a record that will only be rejected with an error because no SSN or HIC number is present is not considered compliant with recording.

Remember that our matching process for both the query and the MSP input file record requires an exact match on either the HIC number or the SSN and then an exact match on three out of four of the remaining fields being the first initial, the first six bytes of the last name, the date of birth, and the gender of that individual. Please refer to the user guide for that information.

At this point, that's all that I had to present and I'll turn it back over to John, or – we've been joined by Bill Decker also.

John Albert: Yeah. There was a question that came in that I'll address regarding a 41125 notice requirements. I'll read the question directly.

During the February 18th conference call, I thought I heard that compliance with MMSEA Section 111 reporting is considered compliant with 42 CFR 41125 and is that correct?

And the answer is that they really are unrelated. Obviously, reporting data through Section 111 means you've done what you're supposed to do in terms of coordinating or performing MSP activity as required, but Section 111 and 41125 are two separate requirements and one does not really affect the other. But again, first of all, 41125 notice requirements might fall outside of the reporting requirements under Section 111.

So, again, they are obviously, you know, – either of them, the point of them is really to report MSP data to CMS and I'll leave it that but they are separate requirements, you know, if you've reported through Section 111 and we have that record and know about, you know, everything essentially that would have been reported under 41125 and they kind of cancel each other out but there

might be requirements in the 41125 that is exceed the scope of the Section 111 reporting so I just wanted to caution the listeners on that one.

So, again, they are kind of exclusive of one another. Bill, do you want to…

Bill Decker: Yeah, hi everybody. My name is Bill Decker and I joined the call a little late but I'm here now, thank you very much for everybody being on this call today. There were a couple of questions that we have regarding multiple employer plans and the definitions of multiple employer plans.

We're not going to address those questions on this call, but I want those folks who've sent those questions into knowing that we got them and we are looking at them now. We do need to determine precisely how we are going to answer the question before we try to answer the question. So, well, we're not going to answer those two questions that came in multi-employer groups today. We will get to them and we will get them with all due speed at least to the degree that we can on our part.

The next set of questions I'm going to address today are the questions that came in regarding HRAs, Health Reimbursement Arrangements. A Health Reimbursement Arrangement is a sum of money that is provided for the use of an employed person and perhaps the dependents of an employed person and that sum of money is provided for that employed person's use by the employer, 100% percent by the employer and no other – no individual contributions are going to be made and the money that is available to the HRA beneficiary as it were is to be used for items that are related to expenditures being made by the individuals or healthcare services or services related to the receipt of healthcare services. The HRAs, as pretty much everybody knows, the definitions are generally provided by the IRS not by CMS. These are employer-employee relationship plans and IRS rules, they govern how they are set up and how they are used.

For the purposes of the Section 111 reporting, we have announced and everyone now knows that HRAs, Health Reimbursement Arrangements, are considered to be GHP, Group Health Plan, coverage for Section 111 recording. In a very short form, what this means is that everybody who

administers an HRA needs to, for Section 111 purposes at least, consider that the HRA is an insurance policy.

If you consider that your product is an insurance policy, it will be – it's much more easy, I think, for everybody who has asked questions about this to deal with what our requirements are in their reporting. Of course, this is specifically a health insurance policy and a group health insurance policy even more specifically than that.

So, that is what – that is where I'm going to start with on the answers to these questions. We had one very long multi-part question coming from one of our RRE reporters and I'll go through bits and pieces of this question and answer as I can. HRAs are not considered to be HSAs as reportable by Section – by RRE under Section 111 as long as beneficiaries don't make a current year contribution, et cetera, et cetera.

We do not deal with HSAs in Section 111 reporting at all and HRA is not an HSA. They are entirely different products. They do entirely different things and an HSA is not going to be considered a group health plan for reporting under Section 111 at this time. That could change but it won't be changed by CMS. It will only be changed by Congress and we have no control or hardly any control or miniscule control over what Congress may or may not do in that area but the – you know, Health Savings Account is not a Health Reimbursement Account. It's not a GHP plan. We will go quickly through that one.

If an active employee covers a Post-65 Medicare entitles spouse enrolled in the company HSA. Again, it's an HSA question. We don't cover HSAs.

It's mentioning the same quarterly update to CMS for HRA if HRA terminates, however what if the HRA does not terminate but the members still enrolled in the HRA and the members next quarter, et cetera, et cetera, et cetera. The HRA considered to be an insurance product, will have – will become actively or will become available to a beneficiary, to a covered person at some point.

Generally speaking, the beginning of a calendar year tends to be what happens with companies that are giving group health plan coverage. Coverage becomes available to all employees at the beginning of a coverage area. If they've been there for a length of time and it becomes available to new hires when they are actually newly hired. That would be the availability – the start date for the coverage.

If the coverage remains in place for the employee after the first term of coverage after the first year, for example, it's still going to be in coverage for the employee and you would not terminate it. You would only terminate your HRA coverage and a notice to us if in fact the employee no longer has access to that insurance. It's just like other group health plan insurance in other words. It functions just like other group health plan insurance and we have – as I've said before, it's easy to think about it that way.

If there is money in an HRA then the HRA value – there should be one in an HRA and the value of that HRA for the term of the HRA which generally speaking is a year and then can be renewed and that would be a new term, but for the year's term and HRA is under a $1000, activity concerning that HRA does not need to be reported under Section 111.

If there is a $1000 or more activity involved in that HRA, does need to be reported under Section 111 if the activity is a consequence of a Medicare beneficiary using the HRA or if allowed by the plan structure, a dependant of a worker who is – and the dependent is a Medicare beneficiary is using that HRA. If so, the activity involved in the HRA must be reported under Section 111.

Let me try to make that just clearer, if it's under a $1000, if the HRA has less than a $1000 in it for the term of the HRA for a year, for example, then that activity does not need to be reported to CMS under the terms of Section 111. If it is a $1000 or more, the HRA is in play in Section 111 and will have to be reported to us. Again, a Medicare beneficiary who is actively working could have access to that HRA or a dependent of an active worked and the dependent is a Medicare beneficiary could have access to that HRA. In either case, the HRA activity would have to be reported to us.

I think that covers pretty much most of those questions, most of the questions that were answered that were asked rather by this one questionnaire.

If I haven't gotten to anyone, I'm sure that I will in the next set of questions.

The next question, actually, is the GHP user guide states that only HRA coverage that are reflective of a freestanding HRA and not linked to other GHP coverage group should be reported? It does not actually say that but it says something similar to that. If the HRA is attached to as part of is a component of other group health plan insurance that has been purchased by the insurer.

It is not what we consider freestanding. We consider that an embedded HRA and think of this way, the HRA – you're going to buy an insurance product from an insurer just for the sake of argument's sake and if anyone from that is on the call, we don't know if you actually do this but we're going to use you as the example.

You sell a GHP product to an employer and as part of the product you're selling to the employer, you include an HRA component. When you report Section 111 data to us, you would be reporting all of your GHP activity including the HRA activity. That's what we mean by an embedded HRA. If Aetna sells a GHP product to the same employer or to a different employer – let's make it a different employer, and there is no HRA part of that GHP coverage that Aetna is supplying but the other employer purchases a separate HRA product from another provider and that other provider administers that product for the employer, it is the other provider who is the RRE in this case and it is administering a freestanding HRA. It is not an embedded HRA.

In our minds at least, this is pretty clear cut. A group health plan product that is purchased by the employer includes an HRA component, it is an embedded component. If it is a separate product that the employer is purchasing, it is not part of a regular GHP insurance. It is not an embedded product. It is a freestanding product and has to be reported separately. We would anticipate that the insurer is selling the embedded product including the embedded product that's part of its GHP coverage will be reporting to us. We will be

anticipating that the entity that is providing the freestanding HRA product to an employer will be reporting that to us that entity will itself become the RRE.

Now, let me see the next question.

John Albert: Please hold on for just a second.

Bill Decker: Yes.

John Albert: We're going to put you on hold just for a second.

Bill Decker: OK.

(This – thanks for holding everybody. This question really involve one particular point that we want to make clear that if the money available on an HRA is not – runs out essentially, is completely used up before the term of the HRA is reached then you don't terminate the HRA. You keep the HRA open and if either was extended for another term or automatically refilled at the end of the year for a new term or whatever, the coverage would continue.

Again, it's on that insurance model. You could have an insurance product that you purchased as regular GHP coverage that had a $5,000 benefit limit for example. It's easy to hit a $5,000 benefit limit during the course of the year. When that's hit, the insurance doesn't pay anymore but the insurance is terminated. It's simply not active anymore. I don't know exactly what the insurance industry's term for that is but it certainly not terminated.

Pat Ambrose: So, in other words, the claims are to be forwarded to that primary insurance first. They will most likely not get paid due to the limits having already been reached and then they're submitted essentially as secondary by the provider of the medical service to Medicare who considers it for secondary payment.

Bill Decker: Right and the classic coordination of benefit model that's what would happen. So, the HRA would still be available to the beneficiary of the Medicare dependent but there wouldn't be any way for the HRA to be used the claim which would go back to the provider and the provider would re-bill, that's how that would actually work. Thanks for helping me out there, Pat.

The next question involves TPA service and a series of questions about whether or not a particular type of plan administered by TPA would be reportable. The first question is an HRA which is administered alongside an insurance already deducted by health plan, et cetera, et cetera, et cetera, pays for deductible. If it's a freestanding HRA and it's paying for insurance deductible, then yes, it's reportable because the deductible is a payment for healthcare services.

It's the same way in the second part of this question, an HRA which is administered alongside and which covers only a portion, et cetera, et cetera, the group health plan. If it's used to pay for any part of healthcare services received by the beneficiary, it's reportable under Section 111.

The third question, the third part of the question that came in here which was – I'll read it all the way through. A general purpose HRA which allows participants to use the employer provided funds to reimburse themselves only for out-of-pocket medical prescription used in mental health coverage which services which are not reimbursable by any other insurance including Medicare, should we report this?

And my answer to that would be something along the lines within a perfect world. The participants would be sure that their benefit expenses were not reportable. We don’t live in a perfect world and we would advice HRA administrators to submit this information on these claims even though the beneficiary or the user of the services may think that they are not reportable or someone else may think they're not reportable. They may in fact be reportable and you're better off telling us about it so we could hopefully figure that out then.

How should we report an inherited HRA? If the participant has died but the dependent widow or widower can continue to use the balance, is that acceptable? Generally speaking, we actually had an interesting conversation earlier today about this question. If a Medicare beneficiary is insured as an active worker and becomes deceased, the Medicare beneficiary is no longer an active worker which would cover any questions about the active recovered individual who was the worker in any case.

If the dependent is able to or has been able to use that worker's insurance, we would assume that generally speaking that the insurance would cancel and the dependent would no longer have access to it but that may not be true. There may be cases where an employer for example wishes to continue coverage as a benefit to the new widow or widower for a period of time.

In such case, we're not actually sure how that would be handled by the Medicare but we have joining us right now, our policy guru, Mr. (Bill Zabonia) and (Bill) will attempt to jump in here and answer at least part of this question. You've just heard me outline what the general question is?

(Bill Zabonia): Yeah. I mean, it depends on what the basis of entitlement is for Medicare. If it's CSRD and it's in the coordination period, Medicare is still secondary.

Pat Ambrose: Now, are you assuming though that the spouse – surviving spouse is a Medicare beneficiary also?

Bill Decker: They would have to be.

Pat Ambrose: OK. I didn't hear that. OK.

Bill Decker: The surviving spouse of the beneficiary who has been using – who has had access to the active worker's HRA. The active worker unfortunately dies, what happens to the coverage of that had been available to the Medicare beneficiary who was the dependent.

(Bill Zabonia): The coverage is still available and the spouse is entitled to Medicare on the basis of the CSRD and if during the coordination period, Medicare is still secondary.

Bill Decker: OK. That's the general answer. If the coverage is still available and that is an issue that isn't really Medicare determined, it can't be determined by CMS. So, the answer to your question is what we thought. If it's still available, the MSP rules still apply in the case of the dependent.

The next question is 3731, Pat, and you actually have your comments on this and if you want to go through them and basically what you thought…

Pat Ambrose: Let's see. I wasn't actually…

Bill Decker: I know you are.

Pat Ambrose: …prepared. I'm sorry. This one was talking about an HRA embedded in a health plan should not be reported separately. If an insurance company administers and reports the CMS data for purposes – for person's covered under a high deductible plan and the employer has a TPA administer the HRA that pays only the deductible amounts under the high deductible health plan enrollment in the HRA conditions and limits it to person's involved in the high deductible health plan. Does the insurance carrier add the HRA data to their submission? Is the TPA the RRE for reporting or is it the employer?

So, If I'm understanding this situation, you have the hospital medical claims portion of the GHP coverage administered, say, by the insurance company but the HRA is administered by a TPA, and in this case in the sense you have two RREs. However, the HRA – again, assuming in this case that it is part of the embedded or it's embedded in the GHP product, the TPA would be the RRE but they don't have to report if the insurer is already reporting the GHP coverage.

So, that's the whole point of the embedded statements in the user guide. The insurer has nothing to add to their report if it's all the same people that they are reporting on their MSP. The GHP covers the reporting on their MSP input file, they don't need to report it with that separate coverage type of R, they would use whatever applies in terms of the insurance coverage type hospital, medical, whatever are the coverages for the entire GHP product. As I've said, the insurer RRE has nothing to add to their report if it's all the same people covered by both and the employer in this case has no role as an RRE from what I could gather.

The question did go on to ask about the effective dates and when you should start reporting. Basically, what we intended was – or we made an assumption that most HRA coverage, most group health plan coverage starts normally, the plan year would start on a quarterly basis. So, if your plan year begins in October 1 and I realized it could November 1 or December 1, it could be

subsequent, but if it begins – if the normal course of the plan year begins in that fourth quarter of 2010, we ask that you report – begin reporting HRA coverage in the last quarter of 2010.

However, if your normal plan year begins January 1st, then you would report your HRA coverage staring in the first quarter of 2011, again, during the assigned file submission timeframe for the RRE ID. So, that's what we were getting at in terms of when you should report, again, based on – it's based on when your normal plan year for that coverage would begin.

Bill Decker: All right. Thanks. Thank you, Pat. There's one more question here about RREs which I'll now address. I think it is one more question, yeah.

This question is a multi-part question but most of the parts actually we've already addressed as to what is the difference in embedded HRA and the standalone HRA and how will a standalone HRA be responsible for coordinating benefits, et cetera. Those are the things we've already addressed. The only question that I haven't addressed that came out on this particular question is, please clarify the $1000 limitation, which actually we think of as a threshold. Should an individual be reported if he or she has the potential of reaching a thousand a year, he or she has currently has a thousand or more, he or she has a thousand or more in their HRA and at first they had plan or something else?

In other words, the provided question is about how we are approaching that $1000 threshold. A simple, – I hope the simple answer for all questions like – all these questions and similar questions is that what we mean by that threshold is that if an HRA has a term of, for example, 12 months at any time and those 12 months there is a $1000 or more in the HRA available to the employed worker or the dependent of the employed worker, then the HRA is reportable under Section 111. It doesn't make any difference really how the money is put in.

When the money is available, the objective here is that if the HRA has a value at the beginning of the term of $1000 and that means that the person for whom

the HRA has been established has at least $1000 to draw from at anytime during the term of that HRA, then the HRA is reportable to us.

One more thing, just in general on subjective HRAs, we refer – a lot of times or implied a lot of times that the term of an HRA is 12 months and that is principally because, generally speaking, GHP insurance that employers have has about a 12-month term for most of it and also because these are – the HRA rules are pretty much set by the IRS and the IRS is a tax year operation and that's why we consider it that way. I'm sorry. Just hang on just for a second, please. I want to put everybody on hold here.

John Albert: We have more point that Bill's wanted us to bring up and address and that's why we went offline just for a second but, Bill, you want to take this…

Bill Decker: This question seems to again, and I'm not faulting the questionnaire confused what is a multiple employer group health plan, a multi or multiple employer group health plan versus a single employer health plan?

It makes reference to a large city HRA being or a large city group health plan being a multiple employer plan because there are multiple agencies potentially with multiple TINS. You aggregate. If you've got 20 city agencies that are part of the city, the employer is the city. Just like the federal government must have thousands of agencies and TINS, the federal government is considered the employer, not each individual agency.

And you also have to remember what we mean by a multi or multiple employer whose health plan is and just basically paraphrasing one of those documents that are on the coordination of benefits' website at CMS.HHS.gov.

The term multiple employer group health plan shall mean any trust, plan, association, or any other arrangement made by one or more employers to contribute sponsor, directly provide health benefits or facility, directly or indirectly, the acquisition of health insurers by an employer member. If such facilitation exists, the employer's considered to be a participant in a multiple employer group health plan even if as a separate contract with the insurer.

So, you have to consider whenever you're thinking about is something the multiple employer group health plan – is there aggregation possible such as there is, say, with the federal government or a city that I know as multiple agency is the City of Chicago and in those cases, it's a single employer which may just consist of multiple – each have multiple TINS and the definition of multiple employer group health plan.

(Bill Zabonia) OK. Thank you, (Bill). John, we'll turn it back over to you. I think we are finished with the questions we are going to address.

John Albert: Yeah, there was just one other thing I wanted to bring up and that is I mention on one of the previous calls that we recently started doing demand notices related to data received on earlier Section 111 files. I just wanted to point that, just experience the date, just to remind everyone to keep an eye on this as that two of the most common errors that are showing up in the recovery process – one is as we've mentioned before time and time again is that the people are submitting retirees as MSP records which again, sometimes we catch wind of this very quickly because the entity realizes then contacts us, but sometime that filter is down to the recovery process and it's only then that we find out that the person was retired and not MSP.

The other common issue that we're seeing is incorrect employer addresses under the new – you can submit an insurer – a demand address as well as the claims processing address. The – I can't remember what the other thing was. (Nathan)?

(Nathan Crawford): Well, when we're receiving these records, there's actually a – we receive incorrect insurer addresses, incorrect employer addresses and what's happening is sometimes they're getting mixed and matched and we're getting these returned and there's actually new language that the user guide talks specifically how to lay these addresses out so they don't – so they are deliverable about how where to put attention to…

Pat Ambrose: Yeah.

(Nathan Crawford): …versus the street address. If they're mixed in the same line, they tend to fail deliverable as a deliverable address. So, make sure you're looking at these

new instructions on how to specifically put these addresses into those fields because it really depends on whether we're able to get those recovery demands and the correct address.

Bill Decker: For the record operator and everyone else, that last speaker was (Nathan Crawford).

(Nathan Crawford): Thanks.

John Albert: OK. That was all that we had. Operator, we'd like to open up the floor to questions.

Operator: At this time, I would like to remind everyone to ask your question, please star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q and A roster. Your first question is from the line of (Scott DeRuth) of Benefit Coordinators. Your line is open.

(Scott DeRuth): I'm was a little bit confused, I think, between the comment on an embedded HRA that said if it wasn't sold by the same entity, the HRA piece of it, that it was not considered embedded but then I think another one of you said that it could be if it was just paying deductibles.

Bill Decker: An HRA product – thank you for your question. An HRA product can either be embedded or freestanding that where we start with it. The product itself is the HRA. If an insurance company selling a group health plan insurance package to an employer includes an HRA component in that package as a part of the package they are selling and the insurance company or whoever is selling this package administers the HRA as part of their general GHP coverage, we would consider that an embedded product. If the product is purchased by the employer on a freestanding basis, that it is not a part of other group health plan insurance coverage, we would consider that to be freestanding HRA coverage. That's how we – that is our definition of an HRA relationship to an employer.

(Scott DeRuth): But is the second product…

Bill Decker: For the purposes of Section 111 reporting, whether or not – if either type of HRA pays a deductible, the HRA is being used to pay for healthcare coverage and the activity from the HRA would have to be reported.

(Scott DeRuth): Right, but if it is acting as an embedded plan? In other words, you require an EOB from the primary, from the HPH, the high deductible plan substantiation for paying the HRA so that any coordination would have happened already under the high deductible plan even though the HRA isn't sold by the same entity – if it's operating like an embedded plan, if it is still not treated when simply because it wasn't sold by the same entity?

Bill Decker: We are pondering you question. I am not entirely sure I understand it frankly.

(Scott DeRuth): Well, for example, let's say you have a high deductible plan and has a $1000 deductible that they bought, let's say from Aetna again and the TPA writes an HRA that only pays the deductible under the Aetna and they have to provide EOB from Aetna to substantiate a claim against the HRA policy, essentially it's acting as if, you know, Aetna could have sold basically the same plan. It only pays when Aetna allows the claim and puts money towards the deductible, so for all intents and purposes it's simply coordinating with the underlying high deductible plan. In other words, any coordination that would happen for Medicare purposes would have already happened on their side before they even applied the deductible?

Bill Decker: OK. We'll – I think we have an answer here for you. There are at least a couple of people here who think they might have your answer for you.

I think we'll start with (Bill Zabonia).

(Bill Zabonia): From what you've describe, I would consider that not to be embedded. The coordination that would take place between the, as you phrased, with the Aetna plan and Medicare would indicate that there is this group health plan deductible and there is nothing available under that group health plan per se to cover that deductible. So Medicare would end up paying that deductible piece of it.

(Scott DeRuth): OK.

(Bill Zabonia): Whereas there is something else available which is the separate plan set up by the employer that is administered by this other entity. So in that sense, I would not consider it to be an embedded product with the group health plan but a separate, if you will, group health plan specifically designed to pay those first hour amounts.

(Scott DeRuth): So, if you were Aetna and you actually supplied the HRA though, you would report it as an insured plan with no deductible then or…

(Bill Zabonia): No, you wouldn't – it would be a situation where there was an embedded HRA and then embedded HRA since it was known to be administered also by Aetna when the claim came in. The HR – the Aetna, since you're using them as an example, would know that while under the regular group health plan there's not any money to pay the plan deductible but if it's placed specifically with the Aetna company that Aetna would know, – well, yes, there is this other thing called the HRA which is available, so that needs to be used as well.

(Scott DeRuth): OK, that makes sense.

(Bill Zabonia): Thank you.

Operator: Your next question comes from the line of (Mildred Liyo) of Blue Cross and Blue Shield of Michigan. Your line is open.

(Mildred Liyo): Hi. I just need some clarification about a scenario that we are running into. A subscriber who was less than 45 years of age and is not ESRD or disabled is an employee of a company with 20 or more employees. His wife is 45 plus years of age, is also covered in the same plan, and is listed as a spouse on a subscriber record. We do not know if the wife is a Medicare beneficiary. But our question is do we send the subscriber on the NMSP file or do we send the wife on the MSP file?

Pat Ambrose: Are you a basic or expanded reporter?

(Mildred Liyo): Expanded.

Pat Ambrose: OK. So the non-MSP file is mainly used to collect drug coverage information on drug coverage that's supplemental to Medicare. And so you're reporting inactive individuals with the D records. Now, you may also submit N records on that non-MSP file as queries but you can't use the non-MSP file exclusively as a query file. If you're only submitting queries and – then you'll have to use the query only file, hence, the name, that ends up getting transmitted in the X12 270/271

OK, that's a – if I understand it correctly, you have – the employee is under the age of 45, not ESRD, not known to be a Medicare beneficiary, that person is not an active covered individual, the employee, and so would not be reported on your MSP input file and would not be reported on the non-MSP file either. You could query that person but there is no need to query them because they are not an active covered individual being under the age threshold with no other information surrounding their Medicare status.

Now the wife or spouse of the employee, I believe you stated, is over age 45, covered by active employment of his or her spouse and is an active covered individual that you need to determine the Medicare status of this individual. So you have a choice of either querying this person first to find out whether they are Medicare beneficiary and then reporting them on the MSP input file. But if you choose not to use the query method first, what we refer to as the finder file method, you may just submit a record with this individual information on the MSP input file.

John Albert: But it's in the subscriber information.

Pat Ambrose: Well, yes. I mean with all the regular information but you are not submitting coverage information for the employee in this case; there is some subscriber information requested on the MSP input file. Now, I can't see a reason for submitting either person's prescription drug information on the D record of the non-MSP file. If anything, Medicare would be secondary and you would submit drug information on the MSP input file for the spouse if they are determined to be a Medicare beneficiary.

But, again, if you happen though to be using the non-MSP input file, non-MSP input file, for reporting of other individual's supplemental drug coverage on D record, you could submit query record and a query record for that spouse who's over 45 on an N record of your non-MSP file.

(Mildred Liyo): OK?

Pat Ambrose: Does that help?

(Mildred Liyo): Yes. Yes, it does. Thank you.

Pat Ambrose: You are welcome.

Operator: The next question is from the line of (April Kane) of (SHPS). Your line is open.

(April Kane): Thank you. Just a quick question about the $1,000. There are some HRAs that are deposit-based specifically if you have an HRA that is built in order to receive incentive deposits throughout the plan year based upon what you or your eligible dependents, what activity you conduct. So it's possible that some individuals may reach a threshold of $1,000; some may not but you won't know until they have reached that threshold. Are we talking about – when we talk about the $1,000 in a given plan year, the 12-month period, are we talking about the balance as of the first day of that plan year? Are we talking about you have – once you've reached that $1,000 threshold, that is your effective date? Or – can you clarify?

John Albert: Yes. The $1,000 threshold was designed for HRAs – HRA administrators and others that provide HRA products, that build HRAs on the assumption that they're going to have a set dollar amount at the beginning of the period. If it is less than $1,000, the activity of that HRA does not have to be reported to us under Section 111. If it's $1,000 or more, it does. Your question is if it's an open-ended HRA and it could conceivably go over $1,000, should that product be reported to us? We don't address that specifically on our user guide but I think we will now. And I think the answer will be that that should be reported to us on the assumption that it could go over the $1,000 threshold.

(April Kane): So in that example, even if I never accumulate personally more than $50 on that HRA over the life of my (inaudible), because it could potentially…

John Albert: Yes. If there is potential for going over the $1,000 threshold in any coverage term, yes.

(April Kane): OK.

John Albert: And what do you mean by personally? My understanding is that the HRA is available not only to the employee but also the covered dependents.

(April Kane): I mean the – in an example where you have an employer that has different incentive benefits that some employees will never ever choose to do smoking cessation or something that would allow them to receive that deposit value. And so you'll have multitude of people with zero balance HRAs for the life of the plan (over year over year).

John Albert: Right. So that means the thing that I focused on was the fact that you referred to he or she would not have that balance available. Usually, the balance in an HRA is available not just to the employee but also to the other coverage individuals under that subscriber.

(April Kane): And the reason I used that personally is because in – for most TPAs you'd be participant of the HRA to actually make that claim against the account. So even though the claim may be for a covered dependent or a spouse, that individual is responsible for making that specific claim.

John Albert: No question about it. But the thing that I wanted to make sure was that we weren't saying, it was only the employee that could have a claim against the amount.

(April Kane): I see.

John Albert: OK, did that help?

(April Kane): Yes. So I just want to recap. So even though it's at zero balance HRA and it may be for the life of the VHRA, we still need to report it.

John Albert: If there is potential that it's $1,000 or more in any term; that's right.

(April Kane): OK. Great.

Operator: Your next question comes from the line of (Yvonne Oak) of Florida Health care. Your line is open.

(Yvonne Oak): Hi. Yes. Good morning or afternoon. My question is regarding the tax ID number. We have two group plans that are both for the State of Florida. And as you mentioned earlier, sometimes states have multiple tax IDs and we weren't really sure how to reflect the correct tax ID number.

John Albert: Usually, there is one tax ID number associated with the administration of the plan. I can think of one state in particular that has multiple agencies with separate TINs but everything is reported under their Department of Civil Service TIN because it was the Department of Civil Service that have responsibility for providing the health benefits. I don't think each (agency) in the states separately contracts for health insurance. It's the State per se that contracts for the health insurance.

Pat Ambrose: OK. I think…

John Albert: Another piece of advice for you is to check with your employer. In this case, the State. Ask them how they want to receive any notices from CMS, if CMS have to send any, how they want to receive and where they want to receive and if there's a particular address they want to use. That's the simplest way. And then when you're reporting activity, that's what you'll report to us.

(Yvonne Oak): Great. OK. Thank you.

Operator: Your next question comes from the line of (Sue Helen Grant) of Unity Health Insurance. Your line is open.

(Sue Helen Grant): Good afternoon. The questions that I have are in regards to delete transaction. I have an example where we sent a member on a 724 file and they're accepted with an effective date of 1/1 of 09, open ended. And then we sent them again on a 10/26 file as an update with a term date of 8/31 of 2009.

If we later find that this person is a retiree and were – with respect to the original effective date of 1/1/2009, should we send the delete with the 1/1/09 open ended or a 1/1/09 with the 8/31/09 term date.

Pat Ambrose: It really doesn't matter. It's what simpler for you – the matching criteria does not use the term date, so it's using the effective date. So, you know, if you send a delete, it's going, you know, and think of it that there is really only one record sitting out there, one MSP occurrence that begins on 1/1/09 and that's what you're trying to delete, so it doesn't matter.

(Sue Helen Grant): OK. And one other question in regards to a member that's sent with no HICN and they're accepted. We later updated the HICN in our system but because those key fields all matched and we're sending it again as an add, you would only store the one record. Correct?

Pat Ambrose: Correct.

(Sue Helen Grant): OK. That's all I have. Thank you.

Operator: Your next question comes from the line of (Beatrice Reyes) of Blue Cross and Blue Shield. Your line is open.

(Beatrice Reyes): Yes. I think more than once people are asking about this multiple tax IDs. And the real scenario that we are experiencing, we could have a university with maybe seven different entities that composes the benefit plan. And in some instances we do have expansive plan or (in others) that govern themselves differently where we even are building – billing them individually. And I know the purpose of establishing in the case of multiple employers where the demand letter should be going to such as employers get the letter and we get a copy.

It is critical that the right entity gets them. They're funded individually. They're not funded as one plan and sold operationally. We are required to do individual mainly for other part of our business and when it comes to CMS, that's a challenge for us when we are being asked to put them all together with one expansive plan representing them. And since timing is of essence when it

comes to demand letters, we want to make sure that the appropriate entity gets those letters so that they could reply on timely message.

Pat Ambrose: Can you hold on for just one minute?

(Beatrice Reyes): Sure.

John Albert: And I guess – your question kind of touches on two areas. The first is in terms of, you know, at the record level, in terms of reporting information, you know, you can report the associated address and TIN as required – as you need for purposes of claims processing as well as recovery actions at that individual record level. It seems, you know, it sounds like they're concerned about, you know, if they're considered one plan sponsor who do they send…

Pat Ambrose: Great. I mean this is a single employer – it's considered one single employer. It's not a multiple multi-employer group health plan. But what we are saying is that when you're submitting – and so when you count the number of employees, for example, you must count at the university level not by separate TIN.

John Albert: University system level.

Pat Ambrose: University system level.

John Albert: Yes.

Pat Ambrose: But when you're submitting your records, I mean, I'm only guessing that if you're administering these plans separately for the various departments or entities underneath the university, you might have separate group numbers. But even if you don't, for the records associated with department x versus department y or, you know, whatever the distinction might be, you can submit separate TINs, you know, as long as, again, the employer size reflects the entire overall employer but you can submit the separate TINs as you indicated with the address to where demand information for that, you know, particular GHP coverage should be sent. And we certainly are interested in having those demands go to the right location as well to streamline their process.

(Beatrice Reyes): OK.

Pat Ambrose: So does that help answer your question?

(Beatrice Reyes): It does because, you know, when we were referencing the guide, it talked about collapsing and just establishing the expansive plan. But if I'm understanding correctly, we can have separate individual TINs and then the respective address so that way when demand letters are issued, they go to the appropriate address and the right entity will get them.

Pat Ambrose: Yes. And you would be submitting those employer TIN records on your TIN reference file with us and a TIN indicator of E as in Edward for the employer, you know. An example of the compression into the plan sponsor would be a union, for example, that is the plan sponsor. There are multiple employers involved for the individual covered by the plan. But the plan sponsor is the union and in that case we want the TIN of the plan sponsor or the union to be submitted with that indicator of the (inaudible) for the sponsor. But in your case it sounds like individual employer TIN should be submitted. It is not a multi-employer group health plan. OK, thank you.

(Beatrice Reyes): Thanks.

Operator: Again, if you would like to ask a question, please star and the number 1 on your telephone keypad. Your next question is from the line of (April Kane) of (SHPS). Your line is open.

(April Kane): Thank you for talking another question and I apologize but it's a little bit new for us, so – with HRA, so bear with me. Trying to work through the participant experience for the HRA, MSP portion. So let's say, for example, we have a standalone HRA. And so – well, we've been using Aetna. So Aetna is my primary insurance. I have a certain out-of-pocket associated with that insurance. And so HRA then would come into play for a participant. So in the normal course of business, I would go and I would incur a $30-copay. And then that $30 would have to be paid by me, the participant, and then I would I submit that $30 for reimbursement to the HRA TPA.

So in that circumstance, I'm trying to understand how coordinating payments work with the new MSP reporting requirements. Because the primary, the provider, will never have information on file to coordinate any certain benefits with the HRA TPA, what actually occurs in just a real life scenario for that participant? Are they going to have to work to help coordinate benefits? Are they – and this isn't – if someone could process – (flow) this out, that would be great. I'm just trying to understand, if we had to explain it to a participant today, what the difference would be between what happens now and what would happen in February of 2011.

John Albert: The participant by a participant – can I make the assumption that you're talking about a human being?

(April Kane): A human being, a person that has – that is covered under a group health plan by a health carrier…

John Albert: Right.

(April Kane): …and group health plan by a HRA TPA…

John Albert: Sure.

(April Kane): …that are not tied together.

John Albert: Let's take the case of a worker who is a Medicare beneficiary. It had to – this involves a Medicare program. And that worker has access to an HRA that's a $2,000 limit for the year, OK?

(April Kane): Yes.

John Albert: Just for the sake of argument. The worker goes to a – gets – he gets some disease and goes to a hospital and gets an operation and has medical bills which are then submitted to the GHP, the primary GHP payer. If there are copays, deductibles and other items that come out of the covered person's pocket, the covered personal (inaudible) seek reimbursement for those payments from the HRA administrator. We're all – we're on the same page so far?

(April Kane): Yes.

John Albert: Under Section 111 reporting, since this is an HRA that has a $2,000 limit, it would have to – that is a reportable – that's reportable to us under Section 111. The HRA administrator reports that payment activity to us, not the individual covered beneficiary; it's the administrator who does. The group health plan is reporting activity to us. We know what we are being asked to pay. We have contractors that are responsible for making sure that to the best of our knowledge and ability, we could make the correct payments in the correct order based on the information we are receiving from all involved insurers.

One of those insurers, in this case, is the HRA administrator. And as far as the individual covered personality, the human being involved, all of this with any – if it works functionally – functions properly, it's going to be pretty much transparent to the covered individual. Physicians or other providers will be involved because they'll be submitting bills for payments to various insurers. And if one insurer denies a payment based on the information it has, it will – they'll return that request for payment to the provider and the provider will then bill another insurer that it knows about. And that's how it will work.

Ordinarily, under ordinary circumstances, the covered individual such as me, I don't know that this is happening. I go to the pharmacy with my prescription and I pay $10 out of my pocket and I get my drugs. And that is because I have group health plan coverage through my employer. Who my employer's insurer is doing business with is actually of no concern to me. What the relationships between all these players is to each other is of no concern to me as an individual. I just know that I have the coverage and the coverage should work for me.

If it works correctly, that's how it would work. In other words, all the insurers would be telling each other in various ways, shapes, and forms about all the coverage that they're providing for a particular individual.

Male: In other words – and realistically, there (inaudible) no difference in what's being done, (the day) if it's being done correctly, and what will need to be (inaudible) in 2011 except potentially now we have explicit knowledge that the HRA exists.

Male: And is involved in the (inaudible).

Male: It is involved in the (inaudible)

Male: …cycle. Right.

Male: Otherwise, if we had no knowledge and someone wanted to now use the word with quotations around it circumvent the requirements, Medicare could end up paying part of that deductible which would not be proper since the HRA was available to pay it and the individual was an active covered employee under the MSP rules and Medicare was properly secondary.

Male: Did that help you?

(April Kane): I think so. I do. I was just curious of whether or not in traditional coordination of benefits the physician's office would have multiple group IDs on file. So if the denial came back over the first payer, any residual funds with the – or amounts due would be sent to the secondary payer. But since an HRA, as a secondary payer, would not be in the system, I wasn't sure what, you know, from –what technically would occur.

Male: Well, the patient should mention that, "Hey, in addition to the group health plan, I got this HRA." And the HRA funds have to be used before Medicare can get billed.

Female: And so the doctor's office has to be aware not only of the primary GHP coverage but also of the HRA coverage and then the subsequent Medicare and make sure that the claim is first addressed by the GHP, then the HRA, then Medicare?

Male: Right. A physician can bill anybody first if it gets denied at one (inaudible).

Female: But the physician doesn't bill the HRA directly.

Male: No.

Male: No.

Male: No.

Male: And that's exactly right. The physician won't be billing the HRA directly. They could be billing Medicare and could be billing the GHP. The HRA reporting to us gets the HRA into the coordination of benefits loop. Now…

Female: So that when Medicare gets that claim, they are going to book to make sure that the claim was considered by the GHP and the HRA before Medicare.

Male: In other words, what may well happen depending on how the plan works is that covered – that individual with the HRA or if they need to fork over the deductible amount out of pocket and get it reimbursed by the HRA if there's HRA funds available.

(April Kane): Yes.

Male: Right.

Male: And then, to the – after the funds are exhausted, then Medicare can get billed to cover anything that isn't covered.

(April Kane): And I guess that brings me back to the question about we had said that termination shouldn't be sent when funds are exhausted. So how would you know – so in – especially in situations where you have a lot of people with zero balance HRAs where they've never – don't have any funds, how would you know that funds have been exhausted? So is a participant going to have to do – what will that experience be?

Male: There should be documentation coming in on the claim forms somehow or on the provider or supplier. They've got all these different codes that they use, and I don't remember all the different categories because I'm not a billing expert, that would indicate that they had received documentation that there were no more HRA funds available. The claim would then be paid properly

and that information would be available in claims history so that we wouldn't end up pursuing it later.

(April Kane): So in a situation with a TPA, it would be a denial sent back to a participant saying you've exhausted your HRA funds?

Male: Yes.

Male: Right, which they would then share with the physician or hospital or whatever which would end up then coding it in such a way that the, for lack of a better term, the second GHP indicated that the funds – that the coverage has been exhausted for the period.

(April Kane): So for the sake of this, for the participant experience, we're assuming number one, the provider has to – or would know that an HRA exists and number two…

Male: Well, the provider would have to be told that an HRA…

Male: Or the provider should be asking as part of their (in-take) process…

Male: Right.

Male: …what coverage does he have. They're required to do that. Now whether they do it is another story.

Male: Well, let's assume that they're doing it. The participants need to be educated in that if you have Medicare, you need to make sure – when you're asked questions about other coverage, that you need to make sure that you mention that you have this HRA coverage.

(April Kane): OK.

Male: I mean, again, keep in mind Section 111 did not change anything in the MSP statute. It just requires a reporting process so that Medicare can pay correctly, which, you know, because of listing information, it didn't.

Male: And just so you know this, when Medicare becomes available to a person for the first time, that person is asked to tell us, that is Medicare, what other insurance coverages they have. And at that point, we would, hopefully, be told that they have HRA coverage.

Male: They need – in other words, which brings this to point that as an educational process for all of your plan participants, you need – I would suggest that you make sure that they realize that that's – HRA coverage under the Medicare law is considered group health plan coverage.

(April Kane): OK.

Male: See that's – a lot of folks may not realize that.

(April Kane): Right.

Male: It sounds like you may be new in this process and I hope this has been clear.

(April Kane): This has. This has been great. Thank you so much.

Male: Thank you.

Operator: Your next question comes from the line of (Connie Gilchrist) of InsigniaSource. Your line is open.

(Connie Gilchrist): Different questions pertaining to HRAs. Now as you know that to have an HRA and an HAS, you have to be covered under a limited purpose that it would be covering expenses for dental, vision, and preventive care, and some reimbursed premiums for other health coverage. Now Medicare A does not cover any of these expenses, but Medicare B does cover preventive care. So would this type of HRA be reported under Section 111?

John Albert: Yes.

(Connie Gilchrist): OK, thank you. Second, some HRAs reimburse expenses for employees only. It isn't fro spouse and dependents. If it is for an employee only, do we need to report the spouse or dependent data under Section 111?

John Albert: No.

(Connie Gilchrist): OK. Third, if an employer with an HRA has fewer than 20 employees and is not part of a multi-employer arrangement, would this type of HRA be reported under Section 111?

Male: No.

Male: Well, ESRD.

Male: Well, ESRD.

Male: Outside the – other than in the ESRD context.

(Connie Gilchrist): OK. I'm sorry, not sure of the answer then. Would they report it then?

Pat Ambrose: Yes.

Male: They would report it if the active covered individual was – had ESRD.

Male: It was a Medicare beneficiary on the basis of ESRD.

Male: ESRD.

Male: Right.

Male: But in terms of working age, no.

(Connie Gilchrist): A non-Medicare, very well, not by age. Great. That helps us a lot. Thank you very much.

Male: Thank you.

Operator: Your next question comes from the line of (Kelly) (inaudible) of Physicians Health Plan. Your line is open.

(Kelly): Yes. I was just (calling), I want to find out we submitted our (BASES) application back in the end of November. We've continued to follow up with our EDI rep as far as when will it be done and we're continuing to be told it's

being processed. Considering the end of November, I was just curious how long that usually takes.

Female: It certainly does not usually take that long. Could I have your RRE ID please?

(Kelly): 11354

Female: 11354. I'll have someone follow up with you and try to resolve this access to BASE as soon as possible.

(Kelly): Great. Thank you very much.

Operator: Your next question comes from the line of (Jean Johnson) from (BASES). Your line is open.

(Jean Johnson): Thank you. I am asking a follow-up question. Last month, I missed the call but I reviewed the transcripts and there were some discussions about returning data for records accepted as 01 who – the accepted records were returned with split entitlements so the actual dates differed from the data that was submitted in the input file. And based on what I read in the transcript is that you are going to do some more investigation on how the data should be turned if – should be returned if updates or deletes are needed on the (one) record. Should the original data submitted from the input file be sent? Or should the dates be adjusted to reflect the split entitlement?

Female: To be – I do plan an update to the user guide for this. Ninety-nine percent of the time you can continue to send one record with the original GHP effective date and not a split, in a sense, your coverage and maintain it separately. But there are cases where if the coverage terminates, for example, prior to the date of the split, the – and I'm just going to call it that. It's not a great, you know, technically accurate term but I think you know what I mean.

(Jean Johnson): Yes.

Female: In that case, there might be problems with subsequent updates and deletes. Because essentially, how the system works is to take your date coming in and first, you know, take your record coming in and apply the split logic to it, so

to speak. So, again, you know, 99 percent of the time it's going to first take your incoming record whether it be an add update or delete, split it, and then apply the two pieces accordingly, how it sort of needs to going forward. But again, in the case of, you know, a termination date prior to that split, you could be left with records out there that never get deleted that should have been deleted. So to be absolutely accurate, the – really, in the case of a split entitlement and getting two response records back, the best thing would be to then to maintain those records using the MSP effective date returned to you on the response record going forward and in a sense maintain two separate records to be absolutely, completely correct. That would be what you would have to do. So, you know, it might not be the simplest answer but, you know, we're not going to say in the user guide that you must, but you must also be aware that there could be, in rare circumstances, situations where an action that you take might not work the way you think it's going to because of that exception. So did that prod or bring up any further questions or…?

(Jean Johnson): No. I think that's given me enough information to go on for now. Thank you.

Female: OK. And then – and do look forward because I do for the updated user guide with that explanation in it. We'll also add it to the (CDTs) to provide some examples to folks going forward to make it a little bit more clear. I realize it's kind of hard to process the information, you know, listening to it over the phone, so – I do have the answer to that question and would really – and will update the user guide and those (CDTs) in the future. In the meantime, you can continue doing what you're doing now.

(Jean Johnson): Thank you.

Operator: Your next question comes from the line of (Chris) (inaudible). Your line is open.

(Chris): Thank you. And we have a question about a particular group we're having a hard time determining whether or not they qualify as a multiple plan employer. We have a state that we insure the employees of the state. But the employees all work for, you know, the city or the county or – and each one of those has an individual tax ID number, but they all have a – their insurance is

through an umbrella of the State. So would that be a multiple employer plan or would we need to report each city or state with their individual tax ID number?

Male: OK. What's state are we talking about?

(Chris): It's Wisconsin.

Male: OK. What I would want to see – if someone is (inaudible) involved depending on what the state statute says. So if these things were established under state statute that you could send to the mailbox, the question describe the situation and the problem you're having in specific detail and cite the appropriate statute with the links so that we can get to it.

(Chris): OK.

Female: You might put in the title of that email that, you know, that it was requested that you send this question from this, you know, as a result of the GHP call today.

(Chris): OK. Thank you.

Operator: Your next question comes from the line of (Brett Rice) of (inaudible). Your line is open.

(Brett Rice): Thank you very much for the opportunity here again to speak with you. I really enjoyed the exchange from a call that you had where you're going through, you know, the actual example of how you would actually go about trying to recoup and identify, you know, the payments. I think that operational processing really helped, at least me, understand really kind of the end game. But I got a quick question as it relates to – I think we really have kind of a non-embedded arrangement with a third party.

Obviously, I know we are remitting records and (inaudible) to our third parties from a group health perspective. And I just want to clarify. Does that mean essentially that we are – or are not obligated as it relates to an additional

reporting on the HRA if benefits be paid within the calendar year are a thousand or more?

Male: OK. Now remember, the reporting is done in the GHP context by an employer, not by an – pardon me, by an insurer, a TPA, and an – or an employer only if the employer self-insures and self-administers. Now from your description, it sounds like you have two arrangements; one, an insurance arrangement and second, a TPA arrangement with respect to the HRA. That means, the case, the insurer would be an RRE with respect to the insurance arrangement and the TPA would be an RRE with respect to the non-embedded HRA arrangement.

(Brett Rice): OK. And one other question. Any event that a person satisfies the $1,000 threshold for current calendar year and the record is sent over as it relates to the coverage being open, but in the next calendar year, for whatever reason, the individual now does not satisfy that $1,000 threshold. Is there a need for the RRE to kind of close out the loop for that prior calendar year? Or because the HRA may still be open but a lesser dollar amount, does that – does it – should it stay open ended? Does it need to be close to the prior calendar year?

Male: You're seeing that there is a multiple HRA arrangement under the Internal Revenue Code?

(Brett Rice): I'm saying if there's a balance that's left remaining, it potentially could be carried over from one plan year to the next.

Male: OK. That's the employer's option as I recall. It's under the code.

(Brett Rice): And independent of that though, I'm suggesting that, you know, in today's world if a person let's say has a family size of three, possibly the HRA may be, you know, a thousand or greater. But in the event, in the next calendar year, the family dynamics may change. There may only be two people covered and the HRA actually may be less. It may only be 750, for example. So in that scenario, last year they met the condition. This year they don't meet the condition. We sent – or someone has sent in a record, open ended, right, and suggesting the criteria is not met. Do you want to have that (inaudible) or you want to leave it open ended?

Male: You can use the insurance model if that's the case where you have an open insurance record in one year and the next year, it (turns) because it doesn't need to be reported to us anymore or it doesn't exist as far as…

(Brett Rice): So close it down then?

Male: Right, yes.

(Brett Rice): OK, super.

Male: Exactly the same as (inaudible) anything else.

(Brett Rice): Yes, I think that answers it. Thank you very much.

Operator: Your next question comes from the line of (Dina) (inaudible) of Independent Health. Your line is open.

(Dina): …everybody and thanks for beating this embedded issue to a pulp that we, as an insurance carrier, have a TPA built within our insurance company and I just want to clarify for all the people involved here at Independent Health, if we ware an insurance carrier for the employee's medical benefit and their HRA, I think you've clearly defined that that is embedded. However, we do have several plans where we are only the TPA but we don't offer the insurance coverage for the employee and therefore don't have access to what medical plan that employee is enrolled in. What do we do in that scenario? Just report on the HRA assuming that it falls into all the other categories?

Male: I believe you would report the HRA as a separate group health plan and I'm assuming the other group health plan is reporting itself as a separate group health plan.

(Dina): OK. So it's not embedded based on the expenses or the enrolment. It's embedded based on whom is offering and administering the plan.

Male: Right.

(Dina): OK. And my second question is we do have several plans where the stipulation for an employee to be eligible is that they're in a retiree category. Some of those plans are for the retiree only. Some are for the retiree and spouses. How do we report if we're required on those types of benefit plans?

Male: Talking about a group health plan arrangement as part of a retiree plan with an HRA?

(Dina): It's actually an HRA as a standalone benefit that are – also the TPA administer for employees that once they retire they're now eligible for an HRA contribution.

Female: If they're not covered by act of employment, then…

Male: (Inaudible) ESRD.

Female: Right. And they don't have – they are not ESRD patients, then they are not considered active covered individuals and it would not be reportable.

(Dina): OK. Perfect. That's what I thought. Thank you so much. That's clear definition of both my questions.

Operator: Your next question comes from the line of (Connie Gilchrist) of InsigniaSource. Your line is open.

(Connie Gilchrist): Yes. Thank you again for taking our call. We just need clarification again on if an employer with an HRA has fewer than 20 employees that's not part of a multi-employer arrangement, would this be reported? And I believe you said yes but then it cut in and out something about an active individual has (ERSD) and Medicare?

Pat Ambrose: Yes. We were talking about ESRD, end stage renal disease…

(Connie Gilchrist): Yes.

Pat Ambrose: If you look in the user guide, there's a definition of an active covered individual and it has certain age threshold based on – and coverage for – current or active employment. And then it also includes individuals that have

had dialysis or kidney transplant and in other words, they are individuals diagnosed with ESERD, end stage renal disease, and regardless of their – of the employment status of the subscriber. So the 20 or more – or the fewer than 20 employee rule applies to people who are entitled to Medicare due to age. Those who are entitled to Medicare due to disability, there is a threshold of 100 or more employees for that employer. If the individual is entitled to Medicare due to ESRD, there is no employee count and nor does the – that applies to Medicare secondary payor status and nor is there --nor does the employment status of the cover or the subscriber have any bearing on it.

There are other rules that apply to ESRD.

(Connie Gilchrist): OK.

Pat Ambrose: So basically, we are saying that if no one in that plan is entitled to Medicare due to ESRD then you would not have to report.

(Connie Gilchrist): OK, thank you very much.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad. Your next question is (Brett Rice) of General Electric, your line is open.

(Brett Rice): Thanks again, I've got one just follow up question and this really kind of goes out to the CNS team and kind of curious on with the Section 111, have you had or have you had an experience or can you share any experiences where you found that employers are kind of doing audits of the data let's say that the RREs are let's say, remitting you know, and have you had any success with that?

Obviously, you know, the employers are responsible and I'm just kind of curious if what recommendations if any that you all may have out there to ensure the quality of the data and is that a recommendation that you would suggest?

John Albert: This is John, you know, in the past, under the VDSA process, we've had overlaps and this is for people in the audience who remember the voluntary

data share agreement process which kind of – was used as a model for this reporting process.

We did have – you know, we did have overlap between employers and insurance carriers and we know that in some cases, employers worked very closely with their insurers to make sure that they are reporting data or in the case of some large national employers, they basically required their insurance carriers to enter into voluntary data share agreements with CMS as well because they wanted to ensure that they weren't being bombarded with recovery demand notices, they wanted their insurance carriers to coordinate benefits timely which is what this and the VDSA process allowed.

In terms of recommendations, I mean we can't recommend enough that the key to accurate and timely and complete data that the beneficiary employer and insurer need to keep in touch with one another because the insurer doesn't necessarily know for example that the guy retired last week and it is – you know, we definitely encourage, you know, those parties to communicate and part of enhanced process with this will be as we talked about in the past, for example, the unsolicited response file process that should allow insurers to know that hey, somebody is contradicting the data I submitted under Section 111 and most likely that contradiction would come from the bene or employer, so yes.

I mean it's a mutual – I mean in terms of the GHP world, it's a mutually beneficial process for the insurer and employer to work together because paying it right the first time is a lot cheaper and also, it's also because of the access to the query data, it also allows the insurer or employer to take advantage of that so if they are also not making their own mistake in primary payment.

So to me, it's a very natural partnership and so I would encourage it, that's all I can say.

(Brett Rice): And probably would also help to kind of limit those issues to the bombard – both of our customer service centers as well.

So even a random audit, I think, would probably be in store just to ensure that you know, folks are – and when there's differences, they can certainly hold them accountable I think for correction which I think I heard Pat continually say. It's a responsibility of the RRE to go back in and correct obviously with their EDI reps, so….

John Albert: I mean, we are looking at the data that we are receiving already especially on the GHP side and as I mentioned, there are some common issues that have come up and we will use that you know, to basically hopefully improve the processing, get the word out there and redirect our outreach and education efforts but it is also being used to look at, you know, in terms of compliance issues as well.

So you know, we're looking at the data that we receive and we want to provide that you know, hopefully as constructive feedback to the reporters, but again, their customers, the employers, are the ones who have ultimate kind of power over the data being sent or not sent and things like that. So are we…

(Brett Rice): I appreciate that feedback, John. So I think I'll definitely take that to (Harton) and I think it might be something we are definitely going to investigate. So I definitely appreciate that.

John Albert: All right. Thanks, (Brett).

Operator: Your next question comes from the line of (Ed Grimm) from (Healthscope Benefits). Your line is open.

(Ed Grimm): Thank you for taking the call. We were one of the RREs who unfortunately submitted a large number of retirees on our file in err and one, I wanted to say that our EDI representative has just been wonderful in helping us to work past the issue so she has just been extremely helpful and supportive so I wanted to state that.

The question that I've got is in regards to the correction file that we submitted. She has helped me to understand in terms of records that has been matched, but one of the questions I've had that she said cannot be answered is trying to determine the number of records that have actually been applied and updated

so I can help keep our own customer servicing claims staff involved of a number of records that has been updated so we can anticipate dropping calls as a result of our err.

Is there any way to determine the number of records that have been updated or any kind of timeframe like that?

Pat Ambrose: We should be giving response files back, maybe I'm not completely understanding the question.

(Ed Grimm): Well, I understand that I would get a response file approximately 45 days after we have submitted our delete file, our file for the records to be deleted…

Pat Ambrose: Correct.

And in that file, for any of the deletes that were successful, you will receive an 01 disposition code.

(Ed Grimm): Correct, and I understand that, it's just we submitted our file this week and again, it had a large number of retirees and…

Pat Ambrose: And you are looking –

(Ed Grimm): Yes, I mean.

Pat Ambrose: Looking for a faster response?

(Ed Grimm): Some kind of a response so that I'd know that whether 1,000, 5,000, or 10,000 records have actually been applied and updated so I can again, keep our claims and customer service staff updated.

Pat Ambrose: Yes. I mean those files will process fairly quickly but I don't k now of a way to tell you how many out of the files have, you know completed versus not. And you will get that response file back to you as soon all records have finished processing, it won't wait for 45 days.

(Ed Grimm): OK.

Pat Ambrose: So hopefully, you'll get them back, you know a lot, lot quicker than that but I don't off the top of my head, know of a way to give you sort of an interim status either. You know, I can go back and look at that and you know, be in communication with the EDI reps if I do know but I don't right now, know how we could monitor that until the actual file completes.

John Albert: I mean assuming you are sending delete transactions for records that preciously posted successfully and had 01 – you know, you got an 01 disposition…

(Ed Grimm): Yes.

John Albert: Assuming all things remain equal, those should be processed pretty quickly. Now, if you make changes to that data, then that could cause other errors but most of their – if the record is clean, it generally processes very quickly like a couple of days.

(Ed Grimm): That's what she tells me,24 to 48 hours is most of the records will be updated and that was three days ago that we submitted the file and of course, I'm still getting inquiries from our own claims and customer staff because providers are – all the records haven't been update so some providers are still being told that records have not yet been updated so I'll just – if there is some way for me to report to our folks well, at least I know 80% or 90% have been updated but I'm hearing you say that we can't really determine that…

Pat Ambrose: I don't know of a way at this point in time so we can take that back and look at it.

(Ed Grimm): OK. But for what it's worth, our RRE number is 10767,and I want to again state that our EDI representative has just been wonderful in our implementation and help us with this…

Pat Ambrose: We really appreciate that feedback on your EDI representative, of course, they work very hard to get back to you folks on your issues and we also appreciate your diligence in correcting this retiree….

(Ed Grimm): Well, we're sorry it happened but at the same time, again, she has just been wonderful to have. So thank you very much for taking the call.

Pat Ambrose: Great.

John Albert: Thank you.

(Ed Grimm): Sure. Good bye.

Operator: Your next question comes from the line of (Barbara Colithan) of Sungard. Your line is open.

(Barbara Colithan): Hi, I heard what I thought might be conflicting answers on terminating the HRA information so this might help clarify it for me. So the $1,000 plan having $1,000 means it needs to be reported. Is it a required – is that a requirement that you not report it if it doesn't meet that threshold or is that the point at which you must report it?

John Albert: If it is $1,000 or more, it is reportable. You must report it if there is activity.

Pat Ambrose: And if you report something that is under that threshold, we won't frankly know and we will post a record for it if all else passes…

(Barbara Colithan): Can it do harm?

John Albert: No.

Pat Ambrose: No.

(Barbara Colithan): To have that information?

Pat Ambrose: No, it was – I think CMS implemented it just to limit the amount of reporting that was required for a very small HRA plan where the threshold would – you know, be…

(Barbara Colithan): OK, OK, so in the event that someone has – say an HRA that rolls a balance over from year to year, once they hit that threshold, it does no harm to

continue to report them year to year if they are still in the plan even if the balance goes up and down?

John Albert: That's right.

(Barbara Colithan): OK.

John Albert: I want to be sure you are clear about it when we say it will do no harm. We are talking about people who are Medicare beneficiaries here and who should be reported in other situations. If you do not report people who are not active covered individuals under our definition, that will do harm to….

(Barbara Colithan): I understand that, it's just – it's a monitoring of the threshold itself that I was trying to get a handle on the diligence under which an RRE has to do that monitoring or if they assure themselves that they are reporting, it went over that, and then based on the way the plan operates, if they fall under that in the next year, if you are going to require them to terminate the record as long as – even though they still are (a participant) in the HRA.

John Albert: I don't think we have a requirement that you must terminate that.

(Barbara Colithan): OK, because I thought I heard someone say that. I thought I was on board until I heard that. OK.

Pat Ambrose: OK.

John Albert: Operator, that's three o' clock, and we need to wrap up. I would like to thank everyone for participating. There were a lot of really good questions especially on the HRA issues on particular. We encourage folks to continue to submit their technical and policy questions to the Section 111 mailbox and again, that is the best way to get these types of questions to us in advance so that we can provide the information or answers responses on future calls or through the user guide and other materials that we put out there.

Right now, I don't think we have any calls scheduled in the future for GHP, right?

(Bill Decker): We don't have any scheduled, we will – undoubtedly have some more but we don't have any scheduled at this time.

John Albert: Yes, so again, keep in touch with the Section 111 website for any updates et cetera. Pat mentioned too based on additional information, we will always be updating the materials like the user guide et cetera to clarify et cetera, et cetera.

So we really do value that constructive feedback from you all, it helps us make better materials.

And with that, thank you very much and operator, if you could stay on after you let the callers go.

Operator?

Operator: Yes, I'm still here.

John Albert: OK.

Operator: They're just disconnecting.

John Albert: OK.

END