INSTRUCTIONS FOR COMPLETING THE GROUP HEALTH PLAN REPORT FOR THE IRS/SSA/CMS DATA MATCH

NOTICE TO EMPLOYERS:

- You are required by law {42 USC 1395y (b) (5)} to complete a Data Match report. The law requires you to complete this Data Match report within 30 days of receipt of your Data Match Personal Identification Number (PIN). Failure to complete the report timely or accurately could lead to the imposition of a civil monetary penalty.
- CMS understands that the Data Match Project will prove burdensome to some employers, but we strongly believe the money saved and recovered through this project far outweighs the burdens. Completion of the Data Match questionnaire benefits employers, Medicare beneficiaries covered by employer group health plans, providers of medical services to Medicare beneficiaries, and the Medicare program. Employers benefit because medical claims involving Medicare beneficiaries covered by group health plans are received and processed more quickly, which reduces administrative expenses and provides better services to covered individuals. Covered Medicare beneficiaries benefit because their claims are processed correctly in the first instance. In almost all cases where Medicare is a secondary payer to a group health plan, the beneficiaries' out of pocket expenses are lower than they would be otherwise. The Medicare program benefits because Medicare makes fewer mistaken primary payments, which reduces trust fund expenses and the administrative cost of attempting to collect inappropriate payments. In addition, providers, physicians, and other suppliers benefit because the total payments they receive for services provided to Medicare beneficiaries are greater when Medicare is a secondary payer to a group health plan than when Medicare is the primary payer.
- Submission options provided through the IRS/SSA/CMS Data Match Secure Web site are convenient and effective methods for completion of the Data Match questionnaire.

  For information on Direct Entry, an internet-based option that allows employers, regardless of size, to complete all questionnaires directly online from multiple locations or the Electronic Media Questionnaire (EMQ) program, which is designed for those employers with the largest number of working Medicare beneficiaries or their spouses, refer to page 14 of this booklet.
- If you are interested in an alternative to completing the Data Match questionnaire response via the IRS/SSA/CMS Data Match Secure Web site, refer to page 16 for information on a Voluntary Data Sharing Agreement.
- Please review the instruction booklet for discussion of the reasons why we are requesting this information and about how you can obtain an extension if you need more than 30 days to complete your Data Match report. Information on the types of questions you will complete is also provided.

ADDRESS:
MEDICARE – Coordination of Benefits
IRS/SSA/CMS Data Match Project
P.O. Box 660 New York, N.Y. 10274-0660
Web site: www.cms. gov/COBGeneralinformation

TELEPHONE:
1-800-999-1118
or (TTY/TDD): 1-800-318-8782

IRS/SSA/CMS DATA MATCH QUESTIONNAIRE

Quick Reference Guide for Employers

To complete the Group Health Plan Report, access the Coordination of Benefits (COB) Contractor IRS/SSA/CMS Data Match Secure Web site at **www.datamatch.cms.hhs.gov**. You will need the 4 digit Personal Identification Number (PIN). This number can be found on your Data Match notification mailing. For further information and assistance, please call our toll-free number: 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.

Questionnaire Part I

- If you answer "NO" to both *Questions 1a and 1b*, **DO NOT** answer any of the other questions in Part I, II, or III. **Proceed to Part IV and fill in the Certification information.**
- If you answer "NO" for **all** of the years identified in *Question 2 and 3*, **DO NOT** answer Questions 4 and 5, nor Part II and Part III. **Proceed to Part IV and complete the Certification information.**
- *For further information on this part of the questionnaire, please continue to page 7 of this booklet.*

Questionnaire Part II

- **NOTE:** Complete this part of the questionnaire only if you answered "YES" to any year in Part I, Questions 2, 3, 4, or 5, and you have offered a group health plan (GHP) to any worker identified in Part III. Fill out information **only** on those GHPs that pertain to these workers.
- Please provide the **complete** name, address (street name/number, city, state, and ZIP Code), Group ID Number or Code, Insurer/Third Party Administrator(TPA) Tax identification number (TIN), Rx BIN, Rx PCN, Rx Group (if applicable), and only **one** GHP type, for each GHP listed.
- **For EMQ Submitters only:** In Part II Each GHP identified must be given a single and unique report number. NOTE: Once you have assigned a Report Number to a particular health plan that number CANNOT be used again in this section of the report. These numbers should not be duplicated, since they are used to identify group health plans for workers identified in Part III.
- *For further information on this part of the questionnaire, please continue to page 8, and 9 of this booklet.*

Questionnaire Part III

- If you answer **"NO"** to *Question 1*, DO NOT CONTINUE. Proceed to the next individual's report.
- If you answer **"YES"** to *Question 1 or 2*, proceed to the questions that follow.
- If you answer **"NO"** to *Question 2*, provide the date the individual stopped working for your organization. If this date is prior to the date specified on the report, **STOP**, DO NOT CONTINUE. Proceed to the next individual's report.

Questionnaire Part III cont'd

- If you answer **"NO"** to *Question 3*, **STOP**, DO NOT CONTINUE. Proceed to the next individual report.
- For *Question 4a*, enter the **LATER** of the following:
  The date specified on the report;
  OR,
  The date that the individual **started** working for your organization.
- For *Question 4b*, enter the calendar date you provided in your answer to Question 2. If no date was given in Question 2, **enter the date you prepared this report.**
- In *Question 5*, report the group health plan coverage selected by the individual during the period between your answers to Questions 4a and 4b. Provide the beginning and ending dates for each period of coverage. Account for any period that the individual was not covered under a GHP by indicating a coverage elected of "NONE."
- **NOTE:** If the individual identified is or was covered by a collectively bargained health and welfare fund, go to **page 12** of this booklet for instructions on how to complete the answer to this question. The GHP Report number should match one of the GHP Report numbers from Part II of the report.
- *For further information on this part of the questionnaire, please refer to pages 10through 13.*

Questionnaire Part IV

- It is essential that this section of the report is completed. Please indicate the name and title of the individual who is certifying this document.
- For further information on this part of the questionnaire, please refer to page 13.

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The projected burden for completing this report is dependent upon several factors. The number of individuals for whom you are requested to supply information has the largest impact on the paperwork burden. Other factors which may increase the burden are the accessibility and format of personnel and health plan records, the number of group health plans offered by the organization, and the frequency of changes between plans or in coverage elections. The projected average burden for completing this report (including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information) is as follows:

Number of Employees for Whom Information is Requested	Estimated Average Burden Hours
1	2
2 - 10	4
11 - 25	6
26 - 50	12
51 - 100	24
101 - 200	48
201 - 1,000	100
> 1,000	200

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer
7500 Security Boulevard
Baltimore, MD 21244-1850

This information is being collected under contract (CMS 500-00-0001) with the United States Department of Health and Human Services for use by the Medicare program.

Background Information

Employer Group Health Plans and the Medicare Secondary Payer Program

Some people who have Medicare also have group health coverage. Usually, Medicare is their primary payer, which means that Medicare pays first on their health care claims. Sometimes, the other plan must pay first. In that case, Medicare is the secondary payer.

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The additional categories of people for whom Medicare is the secondary payer are described below.

Medicare Secondary Payer

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "coordination of benefits" when assigning responsibility for first and second payment.)

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. An employer cannot offer, subsidize, or be involved in the arrangement of a Medicare supplement policy where the law makes Medicare the secondary payer.

(See page v on the IMPORTANT WARNING FOR EMPLOYERS).

Federal law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described below, Medicare is secondary payer regardless of state law or plan provisions. These Federal requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)). Applicable regulations are found at 42 C.F.R. Part 411 (1990). You should verify that your group health plan is in conformity with these Federal documents. The official Federal requirements are contained in the relevant laws and regulations.

Who does MSP affect?

Medicare is now secondary payer to some group health plans (GHPs) or large group health plans (LGHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged,"
- People with permanent kidney failure, and
- Certain disabled people.

As used in this booklet, a GHP/LGHP is:

- a plan that provides health care, either directly or indirectly through insurance or otherwise,
- provided to employees, former employees, or the families of employees or former employees, and contributed to or sponsored by an employer.

A GHP/LGHP includes those plans where employees pay all the costs.

The term *plan* includes insurance plans, prepaid arrangements, and self-insured plans. A plan can be any arrangement between one or more parties for the provision of health care. The arrangements may be oral or written.

Working Aged

The "working aged" are employed people age 65 or over and people age 65 or over with employed spouses of any age who have GHP coverage because of their or their spouse's current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

Medicare is secondary payer to GHPs for the "working aged" where **either**:

- a single employer of 20 or more employees is the sponsor of the GHP or a contributor to the GHP, **or**
- two or more employers are sponsors or contributors, and at least one of them has 20 or more employees.

The "20 or more employees" threshold is met whenever an employer has 20 or more full and/or part time employees for 20 or more calendar weeks in the current calendar year or the preceding calendar year. This may be determined by the number of employees **on the payroll** on any given workweek. To illustrate; The ABC Corporation has 50 employees on its payroll every week. This consists of a staff of 10 full time employees who come in on Monday, Tuesday, and Wednesday and 40 part-time employees who only come in on Thursday and Friday. Due to the number of employees physically on the job for that calendar workweek, the ABC Corporation meets the 20 or more threshold.

When determining the "20 or more threshold," employers (i.e., individual or wholly owned entities) with more than one company must follow the IRS aggregation rules. In cases where an employer wholly owns more than one company, **all**

employees of **all** the organizations in question are counted toward the 20 or more threshold. For example, the XYZ company has six subsidiaries. Each individual subsidiary has a total of 5 employees that worked 20 or more weeks for the calendar year. The 20 or more threshold is met with company XYZ because their number of aggregated employees totals thirty. The relevant IRS codes can be found in 26 U.S.C. sections 52(a), 52(b), 414 (n) (2).

Medicare is the secondary payer regardless of how many employees are eligible to enroll or actually enroll in the plan.

For GHPs with more than one sponsoring or contributing employer, there are three possibilities:

- Where all of the employers have less than 20 employees, Medicare is primary payer for all working aged people enrolled in the plan because the plan is not subject to the MSP provisions.
- Where all of the sponsoring or contributing employers have 20 or more employees, Medicare is secondary payer for all working aged people enrolled in the plan.
- Where some of the sponsoring or contributing employers have 20 or more employees and some have less than 20, Medicare is secondary payer for all working aged people enrolled in the plan. There is one exception: a GHP may request to exempt those working aged people enrolled through an employer with fewer than 20 employees. If CMS approves the request, Medicare would become primary payer for specifically identified working aged people enrolled through an employer with fewer than 20 employees. The GHP must be able to document its decision to exempt such individuals. See page 4 of the instruction booklet, on how you can determine if this exclusion applies to your organization.

People with Permanent Kidney Failure

Medicare is secondary payer to GHPs during a 30-month coordination period for beneficiaries who have permanent kidney failure (End Stage Renal Disease), and who have coverage under a GHP on any basis (current employment status is not required as the basis for coverage).

Disabled People

Medicare is the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a LGHP based on the individual's (or a family member's) current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

A LGHP provides health benefits to employees, former employees, the employer, business associates of the employer, or their families, that covers employees of at least one employer with 100 or more employees.

Employer Responsibilities under MSP

Employers have a number of important responsibilities under the MSP law:

- To assure that their plans identify those individuals to whom the MSP requirements apply;
- To assure that their plans provide for proper primary payments when the law makes Medicare the secondary payer;
- To assure that their plans do not discriminate against employees and employees' spouses age 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is secondary payer; and,
- To timely and accurately complete data match reports on identified employees.

Working Aged

If you are an employer with 20 or more employees, your GHP must not discriminate against employees age 65 or over, or employees' spouses age 65 or over, whether or not they have Medicare. The benefits offered to these people under your plan must not differ in any way from the benefits offered to people who do not have Medicare. Your GHP must be primary payer for those benefits in MSP situations and must not take into account working aged people's entitlement to Medicare.

GHPs must not, for example:

- fail to make primary payment, or make a smaller payment, on behalf of someone for whom Medicare is secondary payer,
- reduce or terminate coverage of employees and employees' spouses age 65 or over, either (1) because they have become entitled to Medicare, or (2) because they have attained age 65.
- refuse to allow employees and employees' spouses age 65 or over to enroll, or to re-enroll, on the same basis as younger employees and spouses,
- impose limitations on benefits, exclusions of benefits, or reductions in benefits on those age 65 or over that are not applicable to younger people who are enrolled in the plan, or
- impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefits, or more restrictive pre-existing illness conditions for those age 65 or over than are applicable to those under age 65 who are enrolled in the plan.

You must inform employees and employees' spouses who are entitled to Medicare that they may reject coverage under the plan and choose Medicare as their primary payer. If they reject coverage under the employer plan, you may not offer them or facilitate or subsidize a plan intended only to supplement Medicare's benefits. Employer plans may, however, offer them

coverage for items and services for which Medicare provides no benefits (for example, eyeglasses).

Beneficiaries who reject the employer plan may purchase Medicare supplemental (Medigap) coverage from some source other than the employer. The employer may not subsidize, purchase, or be involved in the arrangement of an individual supplement policy for the employee or family member.

People with Permanent Kidney Failure

For people who have Medicare entitlement or eligibility because of permanent kidney failure, during the first 30 months of that eligibility or entitlement, the GHP must be the primary payer. They may not take into account their eligibility or entitlement to Medicare based on permanent kidney failure.

The GHP must not, for example, fail to make primary payment or make a smaller payment on behalf of someone for whom Medicare is secondary payer.

In addition, the GHP must not discriminate against them because they have permanent kidney failure. The benefits provided must not differ in any way from the benefits provided to persons who do not have permanent kidney failure.

For all people with permanent kidney failure, with or without Medicare, both during and after the 30-month period, the plan may not:

- refuse to allow an individual with permanent kidney failure to enroll, or to re-enroll, in the plan, on the same basis as persons who do not have permanent kidney failure,
- fail to cover routine maintenance dialysis services or kidney transplants at the same level as other services covered by the plan when the plan covers other dialysis service or other organ transplants,
- impose limits on benefits, reduce benefits, or impose exclusions on enrollees who have permanent kidney failure that are not applicable to enrollees who do not have permanent kidney failure, or
- impose higher premiums, higher deductibles or co-insurance, longer waiting periods, lower annual or lifetime benefits, or more restrictive pre-existing illness conditions than are applicable to those who do not have permanent kidney failure.

Disabled People

A LGHP must not discriminate against disabled Medicare beneficiaries for whom Medicare is secondary payer. This means that it must not treat these people differently from other enrollees because they are disabled and have Medicare.

For example, with respect to these disabled Medicare individuals, a LGHP must not:

- fail to make primary payment, or make a smaller payment on behalf of someone for whom Medicare is secondary payer,
- terminate coverage on the basis of entitlement to Medicare,
- provide for different benefits, or a different level of benefits, on the basis of entitlement to Medicare, or
- charge a higher premium than it charges to other enrollees in the plan.

Employers must offer disabled Medicare beneficiaries the opportunity to reject the LGHP's coverage. In that case, Medicare becomes their primary payer, and the employer must not offer them, subsidize or be involved in the arrangement of supplemental (Medigap) coverage, except for items and services for which Medicare does not provide coverage (for example, eyeglasses).

However, as with the working aged, beneficiaries who reject the LGHP may purchase Medicare supplemental coverage, Medigap, from a source other than the employer, so long as the employer does not purchase, subsidize, or arrange for the coverage.

Making MSP Work

The health insuring organizations under contract to pay Medicare claims (Medicare carriers and intermediaries) are responsible to deny claims for primary benefits when Medicare is secondary payer. These contractors are also responsible for informing providers, employers, insurers and beneficiaries about MSP and how it works. Staff members from Medicare contractors give talks on MSP to hospital groups, insurance associations, beneficiary advocacy organizations and others. A representative of a Medicare contractor in your area would be happy to talk with you about MSP or any other Medicare issue you would like to discuss.

In making claims processing decisions, the Medicare contractors utilized information on the claim form and in the Medicare systems of records in order to avoid making mistaken primary payments. These payments are made by Medicare where a GHP or LGHP should properly be the secondary payer not the primary payer. In such cases, Medicare will not pay the claim as a primary payer and will return it to the claimant with instructions to bill the proper party.

Sometimes, after a Medicare claim is paid, a Medicare contractor gets new information that indicates Medicare made a primary payment by mistake. Based on this new information, the contractor seeks to recover the mistaken Medicare payment. Contractors will send initial demand letters for repayment to any or all the parties obligated to repay Medicare. These parties include the plan, employer, other plan sponsor, insurer, and third party administrator. The parties will

be advised that it or its claims processor must take specified actions to resolve the repayment request.

If the parties do not directly (or arrange with its group health plan or claims processor to) refund the mistaken payment or provide the documented defense to the contractor as requested in the demand letter, the contractor refers the case to CMS.

CMS will review the case. CMS may refer the case to the Department of Justice for legal action if it determines that a properly documented defense or the required payment has not been provided. The law authorizes the Federal government to collect double damages from any party that is responsible for resolving the matter but which fails to do so.

CMS may also refer the case to a debt collection center or the Treasury Department for collection pursuit to the provision of the Debt Collection Improvement Act (DCIA). CMS may refer any or, all the parties that are responsible for payment for collection purposes. Under the DCIA, the government may take direct action to collect debt from any responsible parties or may also offset varies federal payments that may be due to any or all the parties against the outstanding debt.

CMS may also report employers that sponsor or contribute to GHPs that fail to follow MSP rules – these are called "nonconforming group health plans" – to the Internal Revenue Service (IRS). The IRS is required to impose a tax on the employers or employee organizations that contribute to these nonconforming plans. The tax is equal to 25 percent of all contributions the employer or employee organization made to all group health plans during the year. This tax provision is found in Section 5000 of the Internal Revenue Code (26 U.S.C. 5000).

IMPORTANT

WARNING FOR EMPLOYERS: CMS wishes to make sure that employers understand the legal consequences of purchasing directly or indirectly an individual Medicare supplemental (Medigap) policy for an employee or spouse of an employee. This arrangement constitutes a GHP under Medicare law and the Internal Revenue Code. Employers must understand that even if they do not contribute to the premium, but merely collect it and forward it to the appropriate individual's insurance company, the arrangement must be a primary payer to Medicare. In addition, the plan, because it takes into account the Medicare entitlement of the beneficiary, is also a non-conforming GHP which would subject the employer to possible excise taxes. If you have provided such coverage to Medicare beneficiaries, we urge you to write to CMS, Office of Financial Management, Division of Financial Integrity to explain the situation and to take appropriate corrective actions.

Important Notice on Potential Health Insurance Costs Reduction (OBRA 93 Transition Process for Disabled Medicare Beneficiaries)

The Centers for Medicare & Medicaid Services is issuing this important alert to all employers. Specifically, this notice advises you that Medicare can become primary payer for certain disabled Medicare beneficiaries for whom your group health plan may currently be making primary payment. This means that your health insurance costs could be reduced.

HOW DOES THIS WORK?

Effective August 10, 1993, § 13562 of the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"), made Medicare the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a large group health plan (LGHP) based on the individual's (or a family member's) current employment status. An individual has "current employment status" with an employer if he/she is an employee, is the employer (including self-employed persons), or is associated with the employer in a business relationship.

Prior to August 10, 1993, Medicare was also the secondary payer for a disabled individual who was under the age of 65, and who was also enrolled in a LGHP, if Medicare determined they were actively working for the employer despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) or were not actively working but whom the employer treated as an employee. Medicare decided whether or not a person was an "active individual" as defined in the law. For this category of people Medicare is now primary

Because Medicare did not have information to distinguish whether disabled Medicare beneficiaries had that coverage based on current employment status, on July 14, 1994, CMS published a notice in the Federal Register, at 59 FR 35935, which explained procedures employers could use to transition their affected beneficiaries to the new rules.

WHY IS THIS AN ISSUE TODAY?

OBRA 93 did not authorize Medicare to compel employers to transition to the new rules. As a result, even after Congress changed the law, Medicare found that some employers chose to continue providing primary health coverage to some non-working disabled Medicare beneficiaries when not required to do so. However, recent events have indicated a need to provide you with more information.

We have become aware of several outside groups that have been soliciting employers by offering to manage the entire transition process for the employers. For a fee, these outside groups are offering to submit information to Medicare, on behalf of employers, so as to make Medicare the primary payer for those disabled Medicare beneficiaries that do not have coverage based on current employment status. We have also been receiving inquiries from employers, providers, and Medicare beneficiaries about retroactively applying the OBRA 93 change.

You may be unknowingly placing an unnecessary financial burden on both your company and these disabled Medicare beneficiaries if you are not fully informed of the following:

WHAT YOU SHOULD KNOW:

- Several of these outside groups that are soliciting employers are implying that they have a special relationship with Medicare or, in some instances, are implying that they are authorized to act on behalf of Medicare. These outside groups do not have any relationship to Medicare.

- Employers need not contract with any entity to transition the affected disabled Medicare beneficiaries to the OBRA 93 rules. An employer can make these changes directly with Medicare at no cost. The transition requirements are not complicated. Please call our Coordination of Benefits contractor at 1-800-999-1118 or (TTY/TDD) 1-800-318-8782 and they will give you more information.

- We understand that some employers are being encouraged to seek to make Medicare the primary payer retroactively to as early as August 10, 1993, and that employers are incorrectly being told that Medicare will make primary payments as far

back as 1993. You should know that retroactive implementation may conflict with both your interests and affected disabled beneficiaries' interests. Also, because Medicare may pay only providers and suppliers of medical services, or in some cases, beneficiaries, and because Medicare has time limits for filing claims, you will not likely be able to recover payments as far back as 1993. To minimize your time and costs, and to protect the interest of the disabled Medicare beneficiaries, you may want to consider prospective changes rather than retroactive changes.

- You may be asked to sign a statement authorizing someone to act as an agent on your behalf. You should understand the legal consequences of such an appointment, so as not to create unintended results.

- If you decide to have someone act as your agent, you should be aware that the same agent may represent or seek to represent the disabled Medicare beneficiaries. This could pose a conflict of interest. We have been contacted by some beneficiaries who believe they were asked to sign open-ended appointments of representation or who believe that their best interests were not properly represented.

IF YOU DECIDE TO TRANSITION RETROACTIVELY

- Beneficiaries could be asked to pay Medicare Part B premiums back to the date they enrolled. This could amount to several thousand dollars for some beneficiaries. Conversely, your company may also be liable to your disabled employees for any employee contributions to your insurance plan if you are retroactively changing coverage. These changes could be administratively burdensome for you or your plan.

- Because Medicare primary payments are often less than private insurer primary payments, beneficiary out-of-pocket expenses could go up. Retroactive claims filing could create substantial costs for affected beneficiaries.

- The amount of primary payments that you may be able to recoup will be significantly limited by the following four factors. First, Medicare claims may only be submitted by providers and suppliers of the service, or in some instances, by the beneficiaries. Second, Medicare will not honor new claims if they are not submitted timely. Third, the time frame to reopen claims previously processed for secondary payment would, in most of these cases, be limited to one year from the date the Medicare secondary payment was determined. Fourth, physicians and suppliers that have already received primary payment from a private insurer may be unwilling or unable to refund that payment and bill Medicare.

- There may be additional costs to your company or plan, such as additional accounting and bookkeeping costs, related to making the change retroactive, as well as costs related to properly informing affected plan participants about their options for transitioning.

For further information, please call our Coordination of Benefits Contractor at 1-800-999-1118 or (TTY/TDD) 1-800-318-8782.

Important Information Regarding Employers and the New Mandatory Insurer Reporting Law

Section 111 of the Medicare, Medicaid, SCHIP Extension Act of 2007 requires group health plan arrangements to report information that the Secretary of the Department of Health and Human Services requires for purposes of coordination of benefits. In general, group health plan reports are submitted by the plan's insurer or claims processing party administrator (TPA). The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers, and workers' compensation laws or plans. In order for Medicare to properly coordinate Medicare benefits, Medicare requires the collection of the beneficiary's Health Insurance Claim Number (HICN) or Social Security Number (SSN) and the federal Employer Identification Number (EIN) of the employer, along with other pertinent insurance information.

SECTION 111 REPORTING CRITERIA

Insurers and claims processing TPAs are a reliable source to obtain group health plan (GHP) and large group health plan (LGHP) information. These insurers and claims processing TPAs, known for Section 111 reporting purposes as Responsible Reporting Entities or RREs, are required by law to report specific information on GHP and LGHP coverage to CMS on a quarterly basis for all individuals where Medicare is the secondary payer.

The insurers and claims processing TPAs must report GHP and LGHP information on all individuals meeting the definition of an active covered individual. For purposes of Section 111 reporting, active covered individuals are:

- All individuals covered in a GHP or LGHP age 45 through age 64 who have coverage based on their own or a family member's current employment status.
- All individuals covered in a GHP age 65 and older who have coverage based upon their own or a spouse's current employment status.
- All individuals covered in a GHP who have been receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status.
- All individuals covered in a GHP or LGHP who are under age 45, are known to be entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status. The Health Insurance Claim Number (HICN) must also be submitted.

HOW EMPLOYERS CAN ASSIST

The HICN or SSN and Employer Identification Number (EIN) are required data elements for Section 111 reporting because they are necessary for Medicare to properly coordinate benefits. Your insurers or claims processing TPAs may request this information, and other data related to an insured individual, if that information is not on their files. The CMS encourages employers to work with their insurers and claims processing TPAs and assist them, as necessary, in obtaining the information needed for mandatory reporting compliance.

THE BENEFIT OF EMPLOYER COOPERATION

- Prompt employer cooperation with its GHP and LGHP insurers, or TPAs, will reduce GHP and employer costs associated with the coordination of benefits with Medicare.
- Prompt employer cooperation with its GHP and LGHP insurers, or TPAs, will prevent Medicare from making mistaken payments. Fewer mistaken payments made by Medicare will result in fewer recovery actions against employers.
- Your participation in enhancing the efficiency of obtaining this important information could reduce, or even possibly eliminate, the need for employers to provide insurance information via the IRS/SSA/CMS Data Match questionnaires. If CMS determines that the MMSEA Section 111 mandatory reporting requirements process is successful, CMS will consider requesting that Congress eliminate current employer responsibilities under the annual IRS/SSA/CMS Data Match.
- If an employer does not provide its GHP and LGHP insurer, or TPA, the information necessary and required for Section 111 reporting, the employer is placing its GHP and LGHP insurer, or TPA, at risk for non-compliance with Section 111 reporting requirements.

If you would like further information on mandatory insurer reporting requirements, please visit the CMS Web site at **www.cms.gov/mandatoryinsrep.**

General Information

How to Complete the Data Match Questionnaires

In late 1989, a law was enacted (Section 6202 of the Omnibus Budget Reconciliation Act of 1989) to provide CMS with better information about Medicare beneficiaries' group health plan coverage.

The law requires the IRS, the Social Security Administration (SSA), and CMS to share information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the IRS/SSA/CMS Data Match.

The purpose of the Data Match is to identify situations where another payer may be primary to Medicare.

The Data Match identifies employers of beneficiaries for whom employer coverage, if available, is likely to be primary to Medicare. The law requires that CMS contact these employers to confirm coverage information. Your compliance with this law will identify potential situations in which Medicare is not the primary payer.

This publication is intended to assist and guide you through the timely completion of the Data Match Project (DMP) Questionnaire, Parts I, II, III and IV. You should read through the entire instruction booklet and review your data match report before you begin to complete the report.

Depending on your organization's answers to the questions in Part I, it may not be necessary to complete Parts II and III. It is extremely important that all instructions are carefully and closely read and that all answers to the questionnaires provided by you are accurate.

Applicable Federal MSP requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)) and at 42 C.F.R. Part 411 (1990). You should verify that your group health plan is in conformity with these Federal requirements. This instruction booklet clarifies the procedures for completion of these questionnaires. However, it is not a legal document. The official Federal requirements are contained in the relevant laws, regulations, and rulings.

NOTE: *If you participate in a collectively-bargained health and welfare fund or a multiple employer plan, it may be necessary for you to contact the plan administrator to complete some of the sections of this report. Please do so early enough to assure that you will comply with the time frame stipulated in the law for completion of these questionnaires.*

For example, you may need to contact the plan administrator to find out if there is one employer in the plan that has or has had 20 or more full-time and/or part-time employees during the years listed on your data match report. Also, you would need to find out if there is one employer who has/had 100 or more full-time and/or part-time employees in any year listed on your data match report. DO NOT ask the plan administrator if there is/was an employer with 20 or 100 individuals eligible for coverage or covered under the plan. The requirements of the law are based on the number of employees, not the number of individuals eligible for coverage or covered under a plan.

This report may look different from other reports you are required to submit to the government. A major difference is that certain worker information has already been completed for you. This identified worker information is the result of the IRS/SSA/CMS Data Match process. You should note that these individuals were identified because either the worker or the worker's spouse is/was a Medicare beneficiary.

Any employer that has multiple Employer Identification Numbers (EINs) and would like all data sent to one central location for response may arrange for this. The request must be made in writing, to our post office box address noted below. Please inform all entities in your organization that you are making this request.

The law requires that you complete the enclosed report within 30 days. Employers who willfully or repeatedly fail to report, or who provide inaccurate or incomplete information, may be assessed a civil monetary penalty of up to $1,000 for each individual for whom an inquiry concerning health care coverage was made.

However, if you have thoroughly reviewed this instruction booklet and conclude that the information gathering and reporting will require more than the allotted 30 days, you may request an extension of an extra thirty days by calling our toll-free telephone number: 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.

Any request for an extension beyond these 60 days for filing will require you to detail the reasons in a letter written to:

Medicare – Coordination of Benefits
IRS/SSA/CMS Data Match Project
P.O. Box 660
New York, NY 10274-0660

In general, extensions beyond the 60-day period (the original 30 days and one 30-day extension) will not be granted to any employer who is required to report on less than 150 workers (Part III of the data match report). Extensions beyond the 60-day period for those employers with more than 150 workers will be considered on a case-by-case basis.

If you have more than 150 workers identified in Part III of your data match report and do not believe you can complete the report in 60 days, you should immediately request an extension over the phone and request an additional extension in writing. Your written request should contain the following:

- The name of your organization;

- The employer identification number (EIN) of your organization;
- Any associated EINs if you are a parent organization and wish to have all EINs aggregated; and,
- An explanation of the problem or difficulty that precludes completion of the questionnaire in
- 30 or 60 days and the actions you are taking to resolve the problem or difficulty.
- A proposed completion date.

NOTE: *The assessment of a civil monetary penalty will not relieve the employer of the requirement to provide this information.*

Definitions of Terms Used in These Instructions

The definitions listed below will help you to understand the terminology used in these instructions:

Employer: Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

Group Health Plan (GHP): Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees. This includes plans where the employee pays all costs, i.e., through payroll deductions.

NOTE*: For the purposes of completing this report, the term "GHP" includes LGHPs (Large Group Health Plans).*

-see page ii for definition.

Third Party Administrator: A TPA is an entity that performs certain administrative functions of the GHP but does not provide insurance coverage.

An Insurer:
of a GHP is an entity that, in exchange for payment of a premium, agrees to pay for GHP covered services received by eligible individuals.

Worker Only Coverage: For the purposes of completing this report, "worker only" coverage is coverage that covers the worker, but not the worker's spouse. This option should be used when coverage exists for the worker and their dependents other than the worker's spouse. .

Family Coverage: For the purposes of completing this report, "family" coverage is coverage that covers both the worker and the worker's spouse. This does not include coverage that covers the worker and the worker's dependent child.

GHP Identification Number (or Code): This identifies the policy or contract number(s) under which workers are covered for health insurance. Not all plans issue identification numbers.

Earliest Potential MSP (EPM) date: This is the pre-printed date referenced for each worker on the Part III form(s). It represents the date calculated as the earliest potential Medicare Secondary Payer (MSP) date for either the worker, or the worker's spouse. This date will vary for each worker.

NOTE*: See page ii for definition of MSP.*

Employer Identification Number (EIN): This is the number employers use when reporting employee's earnings to the Internal Revenue Service (IRS). It is often referred to as the employer's Federal Tax Identification Number.

Employee: For purposes of the MSP provisions, an employee is an individual who works for an employer, whether on a full or part-time basis, and receives remuneration for their work. The employees (workers) identified in Part III of the data match report are individuals for whom a W-2 form was filed under your employer identification number.

Collectively-Bargained Health and Welfare Fund: Also referred to as a multi-employer health plan organized under a collective bargaining agreement. An "union" plan is an example of a multi-employer plan.

Multi-Employer Plan: These group plans involve arrangements with "collectively bargained health and welfare funds" (see above).

Multiple Employer Plan: A plan sponsored by two or more employers. These are generally plans that are offered through membership in an association or trade group. An example would be a local small business association who offers those employers who are members of the association the opportunity to purchase Group Health Plan coverage for their employees at a better rate because the employers have joined together to form a multiple employer plan.

Part-Time Employment: Part-time employment for a particular employer is less than whatever hours the employer considers to be full-time employment.

Civil Monetary Penalty (CMP): An amount of money that may be levied or assessed by the Federal government against an organization, corporation, company or individual for failure to comply with existing Federal statutes or laws.

Personal Identification Number (PIN):

This number appears on the Data Match notification letter. It is a 4 digit number that is used by employers to access the IRS/SSA/CMS Data Match Secure Web site.

Tax Identification Number (TIN)

The vast majority of **GHPs** are separate legal entities with unique **TINS** or the **TIN** of the employer/sponsor with a unique suffix. Provide the unique **TIN** of the **GHP** you have identified. If you do not know the **TIN**, you may need to consult your financial officer.

If you need further clarification regarding terminology or other information, please call our toll-free number 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.

Instructions for Completing Part I

Question 1a: Did you offer a health plan to any employee at any time since (pre-printed date)? (full or part-time)

Please answer either YES or NO, if any type of health plan was offered to full time and/or part time employees.

Question 1b: Did your organization make contributions on behalf of any employee who was covered under a collectively bargained Health and Welfare Fund (e.g. a union plan) since (pre-printed date)?

Please answer either Yes or No if your organization makes contributions on behalf of any employee who was or is covered under a collectively bargained Health and Welfare Fund (e.g. a union plan).

NOTE: *If you answered NO to both questions 1a and 1b, you do not have to answer any of the other questions in Part I. Proceed to Part IV and fill in the Certification information.*

Question 2: In the following years, did you have 20 or more employees for 20 or more calendar weeks (this includes full time, part time, intermittent and/or seasonal employees)?

Please answer YES or NO as to whether there were 20 or more full and/or part time employees for 20 or more calendar weeks for each of the listed years.

SPECIAL NOTE: If you are involved in a Multi-employer or Multiple Employer Group Health Plan, it may be necessary for you to contact your plan administrator in order to answer these questions. Employers must follow the IRS aggregation rules to determine whether the "20 or more threshold" is met, please refer to page ii of this booklet.

NOTE: *If there was a year listed in this report for either Question 2, 3, 4 or 5 for which you were not in business, please indicate NO for that year.*

Question 3: In the following years, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 20 or more employees for 20 or more calendar weeks (this includes full time, part-time, intermittent and/or seasonal employees)?

For each of the years listed, check YES or NO as to whether your organization participated in a multi- or multiple-employer group health plan in which there was at least one employer who had 20 or more full and/or part time employees for 20 or more calendar weeks.

SPECIAL NOTE: For a definition of a Multi/Multiple Employer Plan, please refer to page 5 of this booklet **or call our toll-free number 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.**

NOTE: *If you answered NO for all of the years identified in Questions 2 AND 3, you do not have to answer Questions 4 and 5. Proceed to Part IV and fill in the Certification information. (Only Parts I and IV will need to be completed).*

Question 4: In the following years, did you have 100 or more employees during 50% of your business days full or part-time)?

Please answer YES or NO as to whether there were 100 or more full and/or part time employees during 50 percent of the business days during each of the listed years.

Question 5: In the following years, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 100 or more employees during 50% of their business days (this includes full time, part-time, intermittent and/or seasonal employees)?

For each of the years listed, check YES or NO as to whether your organization participated in a multi- or multiple-employer Group Health Plan in which there was at least one employer who has had 100 or more full and/or part time employees during 50 percent of the business days in the year listed.

NOTE: *If you answered YES to ANY of Questions 2, 3, 4, or 5, you will need to complete the remaining sections of this report.*

Some employers may be exempt from the MSP "working aged" rules if they are in a multiple or multi-employer plan. This exclusion may be applicable to your organization if you answered **NO** for each year listed in Part I, Question 2. You may wish to write to the multiple employer plan administrator and ask if the Multiple Employer Plan has requested and CMS has approved an exception to the Working Aged MSP rules that apply to your GHP. You should ask for a copy of the GHP's request and CMS's approval to be certain that you complete the questionnaire correctly. However, no exclusions can be made for End Stage Renal Disease beneficiaries or disabled beneficiaries. Please call the toll-free line (1-800-999-1118), and we will help you determine if your organization is eligible for the "working aged" exclusion.

Instructions for Completing Part II

If you answered YES for any year listed in Part I Questions 2 through 5, you are required to complete Part II. The Data Match will require health coverage information for specific Medicare-eligible workers and/or spouses of Medicare-eligible individuals identified in Part III of this questionnaire. Please note that the employer is **only required to report on those group health plans that supplied coverage for the workers identified in Part III of the questionnaire**.

You **do not** need to complete information on any GHP offered by your organization if there are no workers identified in Part III that have or have had coverage under that GHP. You must include all GHPs under which a worker identified in Part III has or has had coverage during the time period identified for that worker.

The health benefit choices that you may offer to employees may consist of many different health plans and choices under each plan. Additionally, a particular health plan may have had different insurers or claims processors during the time period encompassed by this questionnaire. Each option should be listed as a separate group health plan, even though they all fall under the umbrella of your organization's group health plan.

For example, under an employer's benefit program, employees may select from 16 different GHPs. Some of the plans are fee-for-service while others are HMOs or PPOs.

Each option (fee-for-service, HMO/PPO) should be listed separately. In addition, if the GHPs are structured in a manner that hospitalization claims (e.g., major medical) are processed by one entity and medical services (e.g., physician services) are processed by a different entity, each should be listed as a separate GHP in Part II of the data match report.

Group Identification Number or Code

Provide the group identification number or code of the GHP.

Type of GHP

Below is a listing of the various types of GHP arrangements.

EMQ SUBMITTERS ONLY: For each GHP Report Number, please identify, by a letter from the following table, the type of plan that best describes the GHP arrangement provided by your organization.

A. Insurance (Medical and Hospital)
J. Hospitalization only plan – A plan which covers **ONLY** inpatient hospital services. (e.g., indemnity benefit plans)
K. Medical Services only plan – A plan which covers **ONLY** non-inpatient medical services.
U Prescription Drug Only (in network)
V Prescription Drug with Major Medical (non-network)
W Comprehensive (Hospital, Medical, and Drug [in-network])
X Hospital and Drug (in network)
Y Medical and Drug (in network)
4 Comprehensive (Hospital, Medical, and Drug [non-network])
5 Hospital and Drug (non-network)
6 Medical and Drug (non-network)

NOTE: Please do not include retirement/ pension plans, life insurance plans, dental plans, and or special purpose indemnity benefit plan (e.g., cancer plans).

GHP Tax Payer ID No.

Provide the Taxpayer Identification Number (TIN) of the group health plan. The vast majority of GHPs are separate legal entities with unique TINs or which use the TIN of the employer/sponsor with a unique suffix. You need to provide the TIN of each GHP.

Group Health Plan Name

Provide the name of your plan, e.g., XYZ Insurance, VIP Health Insurance of the United States, ABC HMO, Union Local #198 Health Plan, etc. If your GHP is a third-party arrangement, please provide the name of the third-party administrator. Only use the name of your organization if your plan is self-insured **and** self-administered.

Group Health Plan Address

Provide the mailing address of your GHP including street or PO Box, City, State and ZIP Code. Please make sure that this address is the address where claims are actually filed for covered individuals, not just the corporate office of the GHP.

Pharmacy Benefit International Identification Number (Rx BIN)

Provide the Pharmacy Benefit International Identification Number used for pharmacy routing. All network pharmacy payers have an Rx BIN. This field is required when the Coverage Type is U, W, X, or Y.

Pharmacy Benefit Processor Control Number (PCN)

Provide the Pharmacy Benefit Processor Control Number used for pharmacy routing. Some, but not all, network pharmacy payers use this for network pharmacy benefit routing along with the BIN. This number, if it is used, is required when the Coverage Type is U, W, X, or Y.

Rx Group

Provide the group policy number for the drug coverage. It may be the same as the hospital/medical group policy number.

SPECIAL NOTE: If the coverage type your plan offers includes a prescription drug benefit that utilizes an electronic (EDI) pharmacy data network, we require those numbers. Not everyone using a pharmacy network uses a PCN, but everyone using a pharmacy network will have an Rx BIN, so the Rx BIN is always required when a coverage type of U, W, X or Y is entered. The PCN should be supplied if your drug plan uses it.

All Drug payers that process claims electronically have an Rx BIN, but not all use, or need to use, a PCN. The only two Rx-specific identifiers that are always required when reporting a network pharmacy benefit, indicated by Coverage Type U, W, X or Y, are the Rx BIN and Rx PCN. But please include all other Rx-specific information on the record that your drug plan uses to pay claims, so that benefits can be efficiently coordinated.

Remember only the GHPs for the individuals identified in Part III of the questionnaire must be reported.

Instructions for Completing Part III

You will be supplied with the name and social security number (SSN) of each individual for whom you are required to furnish the requested information.

You are requested to provide information for Part III of the questionnaire as of a defined date that is unique to each worker. The calculation of this date took into account all applicable MSP laws and regulations.

NOTE: This date will vary for each worker.

For **Question 1**, the records indicate that this individual was employed by your organization during the years specified. Please answer either YES the individual was employed, or NO the individual was not employed during any of the specified years.

SPECIAL NOTE FOR RELIGIOUS ORDERS: Members of religious orders that have taken a vow of poverty are exempt from the MSP provisions. **This exemption is only applicable for work being performed for the religious order.** For further information on religious order exemptions, please call our toll-free line. If the noted employee has taken a vow of poverty, answer "NO" to question 1. Do not continue; proceed to the next individual's report.

If you answer NO to this question, DO NOT CONTINUE. Proceed to the next individual's report. If there are no more worker reports, go to Part IV to complete the Certification Statement.

NOTE: The following examples are provided to assist you in completing Part III. The data in these examples should not be used to complete your employer specific questionnaire.

Example (Question 1):

1. Was this individual employed by your organization during 2008 or 2009?
   If the answer to Question 1 is "Yes," continue to question 2.

If the answer to Question 1 is NO, go to the next worker's report.

For **Question 2,** information is requested regarding whether this individual is currently employed by your organization. Check the appropriate box (YES or NO). If the answer is NO, please provide the date the individual stopped working for your organization.

IMPORTANT NOTE: If the individual listed on the report is a re-employed retiree, a seasonal, temporary, intermittent employee, please contact the toll-free line on how to complete Part III, Questions 1 to 5.

If you answered **No** to Question 2, you must furnish a Stop Date, which would be the last day the employee worked. If the last day worked is before the worker's EPM (Earliest Potential Medicare) date, you do not have to furnish any additional information on this worker. **DO NOT CONTINUE**. *Proceed to the next individual's report. If there are no more individual reports, go to Part IV to Complete the Certification.*

Example (Question 2):

2. Is this employee currently working in your organization?
   If the answer to Question 2 is **NO,** enter the date the individual stopped working for your organization (full or part-time).

If this individual stopped working for your organization before *01/01/2008 DO NOT complete Questions 3 to 5.

***Note:** The date given in the above example represents **this** individual's, *and only this individual's*, EPM (Earliest Potential Medicare Secondary Payer) date. This date will vary for each worker and also appears in Question's 2, 3, and 4.

For **Question 3,** information is requested regarding coverage of the

individual under a group health plan (GHP) at any time after the specified date.

The individual may have stopped and started working several times during the Data Match reporting period. For the purpose of answering Question 2, please provide the most recent date on which the individual stopped working for your organization.

If the individual listed was not covered under your Group Health Plan AFTER the individual's EPM date, DO NOT CONTINUE. If you answer NO to this question, proceed to the next individual report. If there are no more individual reports, go to Part IV and complete the Certification.

For example, Mr. Steven Grant worked for the Ace Tire Company from 01/01/2008 (Mr. Grant's EPM date) to 05/01/2008. The last date of employment for Mr. Grant was 05/01/2008. This is the date that should be used as the answer to Question 2.

Example (Question 3):

3. Was this individual covered under a Group Health Plan at any time after **01/01/2008?**

If this individual was not covered under a GHP after 01/01/2008, DO NOT complete Questions 4 or 5.

For **Question 3,** information is requested regarding coverage of the individual under a group health plan (GHP) at any time after the specified date.

If the individual listed was not covered under your group health plan AFTER the individual's EPM date, DO NOT CONTINUE. If you answer NO to this question, proceed to the next individual's report. If there are no more individual reports, go to Part IV and complete the Certification.

For example, Mr. Alfred Green has been employed with Allstate Construction since 08/15/2002. In every year since then, he has been covered under the company's group health plan. Since Mr. Green's coverage continued after the date given, 01/01/2008, the answer to Question 3 would be "Yes."

Question 4a asks you to fill in the **LATER** of (1) the date specified on the report, or (2) the date which the identified individual started working for your organization. If the individual's start date is **after** the pre-printed date given, use the date they started working. If they started working **prior** to the date given, use the pre-printed date on their form.

For **Question 4b**, please enter the information given in your answer to Question 2. This would be the month, date, and year the individual stopped working for your organization. If the individual is currently working, please use the date that you prepared this report.

Example (Question 4a and 4b):

4. Please enter in the box marked 4a below, the LATER of **01/01/2008** or the date this individual started working for your organization. In box 4b, enter your answer from Question 2. If still currently employed, use current date.

For example, Ms. Grey started working for ACE Pharmacy Company March 15, 2008 and stopped working on October 1, 2009. The date listed in question 4a would be 03/15/2008, the Later of the date specified (01/01/2008). The date Ms. Grey stopped working, 10/01/2009, would be provided in Question 4b. This date also would correspond with the date entered in Question 2 for Ms. Grey.

For **Question 5**, information is being sought regarding the type of GHP coverage the individual had or still has during the period between your answer to Question 4a and Question 4b.

Consider full time, part time, intermittent, and seasonal employees when answering Question 5. Provide an answer for each year listed.

Periods of coverage for each GHP are required, including type of coverage offered. Indicate Worker Only coverage if the worker is the only individual covered. Indicate Family coverage if the worker and spouse are covered under the plan.

Account for any breaks in coverage.

For each period of coverage the following information is required:

- Beginning date of coverage
- Ending date of coverage
- Coverage Type
  - Worker
  - Family
  - None
- GHP Name

It is recognized that in some situations, employees will leave employment for periods of time or be laid off and then return to work. These periods should be accounted for in your answer to Question 5. During any interval when the mployee was not covered by a GHP, the coverage elected should be indicated as "NONE". List each period of coverage or non-coverage in chronological order.

SPECIAL NOTE: However, if you have certain knowledge that the covered dependent(s) is someone other than a spouse (e.g., a dependent child), please indicate "Worker Only" coverage. The coverage elected by the worker MUST be indicated for each period of coverage.

Please provide information ONLY for the time between your answer to Question 4a and Question 4b.

Example (Question 5):

5. During the period of time between your answer to Question 4a and your answer to Question 4b, what type of health coverage did this individual elect under your plan? If the individual is still employed by your organization, please complete the following from the date listed in Question 4a to the date in 4b.

For example, Ms. Grey had two period of coverage during the time between 03/15/2008 and 10/01/2009, (i.e., the responses to Questions 4a and 4b). The first period was from 03/15/2008 to 06/30/2008. During this period, Ms. Grey elected a 'Worker Only' policy. When Ms. Grey married on 07/01/2008, she elected to change her coverage to 'Family', but the group health plan remained the same. Her first period of coverage from 03/15/2008 to 06/30/2008 would show Worker Only coverage, and her second period of coverage would be from 07/01/2008 to 10/01/2009, which is the date Ms. Grey stopped working.

Example (Question 5, when there was a period of no GHP coverage):

You must report the coverage selected by each individual for each period of time. Account for any periods that the individual was not covered by indicating coverage elected as "NONE".

If Ms. Grey had two periods of coverage but a lapse between the two, such as Worker Only coverage from 03/15/2008 to 04/30/2008, no coverage from 05/01/2008 to 06/30/2008, and Family (Worker & Spouse) coverage from 07/01/2008 to 10/01/2009, then, three periods of coverage would be reported to list all periods of coverage between 01/01/2008 (Question 4a.answer) and 10/01/2009 (Question 4b.answer).

Period	Beginning Date	Ending Date	Coverage
1	03/15/2008	04/30/2008	Worker Only
2	05/01/2008	06/30/2008	None
3	07/01/2008	10/01/2009	Family

Instructions for Completing Part IV

Part IV Certification asks the employer to verify that the information being provided is complete and correct to the best of their knowledge. This section must be completed because it serves as a certification that the data is valid.

If you have any questions concerning the completion of this questionnaire, please contact the Coordination of Benefits Customer Service Department at 1-800-000-1118 or (TTY/TDD) 1-800-318-8782. This toll-free number is available Monday through Friday, from 8:00 a.m. to 8:00 p.m. Eastern Time.

Information on the Coordination of Benefits (COB) Contractor IRS/SSA/CMS Data Match Secure Web Site

Data Match questionnaire responses are submitted through the IRS/SSA/CMS Data Match Secure Web site. There are two submission options available via the Secure Web site: Direct Entry and Electronic Media Questionnaire (EMQ).

Direct Entry is an efficient and timely response method. Multiple users at multiple employer locations can be designated to complete the questionnaires directly online through the use of a personal computer (PC) with Internet access.

Employers with at least 50 workers for whom they must report may submit their Data Match questionnaire responses using the Electronic Media Questionnaire (EMQ) option. The Electronic Media Questionnaire (EMQ) program is designed to assist larger employers by allowing them to respond to the questionnaire via electronic media rather than manually completing the information through the Direct Entry method. Employers with less than 50 workers should use the Direct Entry method.

WHAT IS DIRECT ENTRY?

Direct Entry is an internet-based option that allows an employer to complete all Data Match questionnaires directly online via the IRS/SSA/CMS Data Match Secure Web site, without the need to download or upload files.

Employers assign an Account Manager, who will have the ability to log into the Secure Web site from any personal computer to complete the questionnaires, or the Account Manager can designate one or more employees at one or more employer locations to complete all or specific parts of a questionnaire.

Data entry screens are completed directly online, and the information provided is validated for accuracy and completeness as it is entered. This allows for common errors to be identified and corrected at the time of submission.

The questionnaire can be completed in one session or saved and completed at a more convenient time. Users have the ability to view and print the completed questionnaire data in summary format for up to 30 days from the date of submission. Interactive Web pages and online documentation take the user through this process effortlessly.

What is the Electronic Media Questionnaire (EMQ) option?

The EMQ method is available to employers with at least 50 workers for whom they must report. Employers choosing this method will download a file of the workers via the IRS/SSA/CMS Data Match Secure Web site, and upon completion of the questionnaire response file, return to the Secure Web site and upload the data.

Those employers who choose to participate in the EMQ program will have certain responsibilities regarding the availability of media, the ability to develop simple software applications, and the availability of a few personnel. EMQ submitters will be required to register on the Secure Web site to submit their file response through the EMQ application. The employer will first download the worker file from the Secure Web site and develop software to create the Data Match Questionnaire response file. Upon completion, the response file is uploaded to the Secure Web site.

This method is the best choice for those employers who have hundreds of worker records to complete within a limited timeframe. The IRS/SSA/CMS Data Match Project Electronic Media Questionnaire (EMQ) Specifications for Employers booklet provides information on the EMQ program specifications, including employer eligibility requirements and the technical aspects of preparing an EMQ data file response. Please review this booklet, which is available on the IRS/SSA/CMS Data Match Secure Web Site at **www.datamatch.cms.hhs.gov**.

GETTING STARTED

Employers, or their designated representatives, are responsible for completing the Data Match questionnaire and will be the users of the Data Match Secure Web site.

There are two user roles on the Web site, Account Manager and Designee. Only one person may be the Account Manager for an employer, but there is no limitation on the number of Designees that can be assigned.

The Account Manager is the person who will control the activity related to the Data Match questionnaire response. He/she is the person who is responsible for establishing the Employer account on the Web site, managing the day to day activity related to completing the Data Match questionnaire, assigning portions of the application to other employees to complete on the Web site, tracking the status of the tasks assigned to others, and ensuring questionnaire certification and submission are completed on time.

The Account Manager is also responsible for inviting other employees to register on the Web site and managing their access. The Account Manager may complete and submit the Data Match questionnaire, including downloading and uploading files for the EMQ response method, or invite designees to assist as needed. In many cases, the Account Manager will be a manager in the employer's Human Resources Department.

Designees are optional users associated with an employer's Secure Web site account who are invited by the Account Manager. These are typically people who report to the Account Manager in the employer's Human Resources Department. The assignment of designees on your account allows your Account Manager to allocate portions of the Data Match questionnaire to different staff members for completion. For example, one Designee may complete the questionnaire for workers in your West Coast operations center and another for the East Coast operations center. Designees can also act as a back up to the

Account Manager for most of the employer's activity on the site.

Designees will be able to perform all of the functions on the Web site, including completing and submitting the company's questionnaire, with the exception of being able to invite additional users. Only the Account Manager can invite and manage the users associated with an account.

Registering for the Web Application

All users must register on the IRS/SSA/CMS Secure Web Site. The employer must designate an Account Manager who after registering on the Secure Web site will have the ability to assign designees and start the online process. When registering, the Account Manager will need the employer identification number (EIN) and 4-digit personal identification number (PIN) for each assigned account. The Account Manager must complete a separate registration process for each EIN. These numbers can be retrieved from the Data Match notification letter received. Your employer will receive a new PIN for each EIN for each Data Match tax year.

The following describes in general terms how to register as an Account Manager on the Data Match Secure Web site. Please refer to the Secure Web Site User Manual, which can be found under the Reference Materials menu option on **www.datamatch.cms.hhs.gov** for more information on the use of this site and step-by-step instructions.

Step 1

Click on the >> Register as a New Account Manager >> link on the Login page of **www.datamatch.cms.hhs.gov**. You will only use this link once to register. After that, you will use your selected Login ID and Password to enter the site.

Step 2

Complete the information on the Account Manager Registration pages as requested. You will need to provide your e-mail address. During this process, you will be:

- Establishing an account for the employer
- Creating your personal Login ID and Password
- Indicating the employer's response method by selecting either Direct Entry or EMQ

Step 3

After successful registration, you will see a Thank You page confirming your registration.

The system will then submit your request to utilize the Secure Web site. The selected employer questionnaire data will be available for processing within 2 business days. If you are unable to access the selected employer's questionnaire data within the aforementioned stated timeframes, please contact the Coordination of Benefits (COB) Contractor at 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired and a Customer Service Representative will direct your call to someone that can assist you.

Note: While the employer's questionnaire data is being loaded, the Account Manager may log into the site and invite Designees to register as users and add accounts for additional EINs as needed.

Registering Additional EINs

If you need to complete the Data Match questionnaire for more than one EIN, you must first complete the Registration process described above. After successful registration as an Account Manager for a single EIN, you can then proceed to adding other EINs as described below.

Step 1

Enter your Login ID and password on the Login page and click **Login**.

Step 2

After you accept the Login Agreement, the EIN Listing page will display.

Step 3

Select **Add an EIN** on the right-hand side of the page and fill in the information requested. Your second EIN will appear on the EIN Listing page after you complete this process.

Need More Information About the Direct Entry or EMQ Options?

General information on the Direct Entry and EMQ options as well as information on registering for this service is available on the IRS/SSA/CMS Data Match Secure Web site at **www.datamatch.cms.hhs.gov.** Information may also be obtained by contacting our office using our toll free lines: 1-800-999-1118 or TTY/TDD: 1-800-318-8782.

Voluntary Data Sharing Agreements

What Is a Voluntary Data Sharing Agreement?

A Voluntary Data Sharing Agreement is an agreement between the Centers for Medicare & Medicaid Services (CMS) and an employer to electronically exchange Medicare and group health plan (GHP) eligibility information. The employer agrees to share GHP coverage eligibility data on policy holders/employees and their spouses. In exchange, CMS agrees to provide the employer with Medicare eligibility information for identified Medicare individuals. This enables claims to be paid in the correct payer order.

What Is the Purpose of a Voluntary Data Sharing Agreement?

The purpose of the Voluntary Data Sharing Agreement is to more efficiently coordinate health care benefit payments between insurers and Medicare in accordance with Medicare Secondary Payer (MSP) and Medicare-related laws.

About Employer Voluntary Data Sharing Agreements

The CMS has entered into Voluntary Data Sharing Agreements with numerous Fortune 500 and other large employers. These agreements allow employers to send and receive eligibility coverage information electronically to and from CMS, producing substantial benefits for these employers. Implementation of a Voluntary Data Sharing Agreement will allow your organization to receive the following immediate benefits:

- Elimination of Requirements to Complete Data Match Questionnaires

A Voluntary Data Sharing Agreement is an alternative way for you to satisfy your requirement to Data Match.

- Improved Timeliness of the Information Being Collected

Instead of completing annual Data Match questionnaires that require you to provide information about employee GHP coverage over the past several years, you agree to a quarterly electronic data exchange of current GHP coverage information with Medicare.

- Elimination of Repayment Claims and Associated Penalties

Voluntary Data Sharing Agreements ensure that all insurers involved in benefits payment, including Medicare, pay primary when appropriate. Paying correctly first can eliminate the need for overpayment negotiations and possible penalties. *Note: Repayment claims arise when Medicare mistakenly pays primary for services that should have been the primary payment responsibility of your GHP. The CMS may recover from any entity responsible for making primary payment, including employers. Failure to respond to repayment requests may result in legal action and/or other collection actions. In addition, under the Debt Collection Improvement Act of 1996, CMS may recover these debts by offsets against any monies otherwise payable to the employer by the United States, including tax refunds.*

- Reduction in Insurance Costs

Voluntary Data Sharing Agreements clearly identify when Medicare is the secondary payer - and when Medicare is the primary payer to your insurer.

- Improvement of Service to You and Your Medicare-Entitled Employees

Voluntary Data Sharing Agreements ensure that health insurance claims for the affected beneficiaries are paid correctly by the appropriate primary payer. Voluntary Data Sharing Agreements identify not only when Medicare is the secondary payer, but also when Medicare is the primary payer. You may not always know if the policy holder/subscriber or their spouse has Medicare. Additionally, you may lack the information to determine primacy or may be confused by the MSP laws and regulations pertaining to End Stage Renal Disease (ESRD). ESRD rules can be complicated, but clear ESRD status data is provided to employers in the Voluntary Data Sharing Agreement data exchange. It can also be difficult to determine if subscribers have entitlement to Medicare due to disability. Even if you recognize that the beneficiaries are entitled, you may not know if Medicare is primary because of employment status and other issues. Voluntary Data Sharing Agreements will allow you to be notified when Medicare becomes primary for these beneficiaries.

- Coordination of Part D Prescription Drug Benefits

Data Received from a Voluntary Data Sharing Agreement allows proper billing at pharmacy point-of-sale transactions and is used to facilitate True Out Of Pocket cost calculation for Medicare beneficiaries enrolled in Medicare Part D.

- Satisfaction of Retiree Drug Subsidy Reporting Requirements

Using a Voluntary Data Sharing Agreement allows employers claiming the employer subsidy on qualified retirees to fulfill their reporting obligations to the Retiree Drug Subsidy (RDS) contractor and provides employers with additional Medicare enrollment data that RDS does not.

If your organization is interested in a Voluntary Data Sharing Agreement, please contact our customer service department for additional information at:

1-800-999-1118, or visit our Web site: **www.cms.hhs.gov/COBGeneralInformation** and follow the links to Employer Services.

42 USC 1395y(b)(5)
Identification of Secondary Payer Situations

(A) REQUESTING MATCHING INFORMATION. –

(i) COMMISSIONER OF SOCIAL SECURITY. -- The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of Medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) ADMINISTRATOR. -- The Administrator of the Health Care Financing Administration (renamed Centers For Medicare & Medicaid Services 6/14/01) shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS. -- In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS. --

(i) IN GENERAL. -- With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) EMPLOYER RESPONSE. -- Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provision of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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