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

A. Background

The Centers for Medicare & Medicaid Services (CMS) seeks to collect various data elements from the applicable reporting entities (see supporting documents) for purposes of implementing the mandatory MSP reporting requirements of Section 111 of the MMSEA. This information will be used to ensure that Medicare makes payment in the proper order and/or takes necessary recovery actions.

"MSP" refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Under the law, Medicare is a secondary payer to Group Health Plans (GHPs) for certain beneficiaries, those:

- who are age 65 or older and working with coverage under an employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (or if it is a multi-employer plan where at least one employer has 20 or more full or part- time employees);
- who are age 65 or older and with coverage under a working spouse's employer- sponsored and/or contributed to GHP, for an employer with 20 or more employees (the working spouse can be any age) (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- who have End Stage Renal Disease (ESRD) and are covered by a GHP on any basis (Medicare is secondary for a 30 month coordination period.); or
- who are disabled and have coverage under their own or a family member's GHP for an employer with 100 or more full or part-time (or if it is a multi-employer where at least one employer has 100 or more full or part-time employees.)

Medicare is also a secondary payer to liability insurance (including self-insurance), no- fault insurance and workers' compensation.

1. Purpose

The purpose of this submission is to set forth what information will be collected pursuant to Section 111 and the process for such collection. The information is to be collected from applicable reporting entities for the purpose of coordination of benefits. Section 111 mandates the reporting of information in the form and manner specified by the Secretary, DHHS. Data the Secretary will collect is necessary for both pre-payment and post-payment coordination of benefit purposes, including necessary recovery actions.

Section 111 establishes separate mandatory reporting requirements for GHP arrangements as well as for liability insurance (including self-insurance), no-fault insurance, and workers'

compensation. (For purposes of this document, these may collectively be referred to as "non-GHP.") The effective date for reporting group health plan information is January 1, 2009 and for non-group health plan information it is July 1, 2009. With the passage of Section 111, CMS now has the authority to mandate the reporting of insurer MSP information. ***(See Attachment A – Definitions and Reporting Responsibilities)***

2. The Federal Role

CMS is responsible for oversight and implementation of the MSP provisions as part of its overall authority for the Medicare program. CMS accomplishes this through a combination of direct CMS action and work by CMS' contractors. CMS efforts include policy and operational guidelines, including regulations (as necessary), as well as oversight over contractor MSP responsibilities.

As a result of litigation in the mid-1990's, CMS received mandatory reporting from certain GHP insurers for a number of years. Subsequent to this litigation related mandatory reporting, CMS instituted a Voluntary Data Sharing Agreement (VDSA) effort which expanded the scope of the GHP participants and added some non-GHP participants. This VDSA process complements the IRS/SSA/CMS Data Match reporting by employers, but clearly does not include the universe of primary payers and has few non-GHP participants.

Both GHP and non-GHP entities have had and continue to have the responsibility for determining when they are primary to Medicare and to pay appropriately. In order to make this determination, they should already be collecting most of the information CMS will require in connection with Section 111 of the MMSEA.

3. Current MSP Information Gathering Processes

MSP is generally divided into "pre-payment" and "post-payment" activities. Pre- payment activities are generally designed to stop mistaken primary payments in situations where Medicare should be secondary. Post-payment activities are designed to recover mistaken payments or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers' compensation which has resulted in a settlement, judgment, award, or other payment.

Most MSP activities are performed by CMS specialty contractors.

Pre-payment activities include:

Initial Enrollment Questionnaire (IEQ) Process: The IEQ is a questionnaire to beneficiaries which permits CMS to determine if there is an MSP occurrence at the time the beneficiary becomes entitled to Medicare.

Medicare's Claims Payment Process: Providers, physician, and other suppliers submitting claims to Medicare include coordination of benefit information on the submitted claim.

IRS/SSA/CMS Data Match Process: Data matched by these three agencies results in questionnaires to employers regarding certain employees' GHP coverage. The information received from employers is used to update CMS records.

VDSAs: Information obtained through this voluntary process from insurers, employers, and a limited number of workers' compensation entities is used to update CMS records.

Self-Identification of an MSP Occurrence: Beneficiaries/beneficiaries representatives contact the appropriate CMS contractor to report changes in their GHP coverage or self- identify a non-GHP occurrence.

Post-payment activities include:

Debt Recovery: A CMS specialty contractor is responsible for pursuing recoveries where CMS records identify mistaken payments as well recovery claims due to conditional payments once a there is a settlement, judgment, award or other payment.

B. Justification

1. Need and Legal Basis

The statutory basis for this information collection is Section 111 of the MMSEA which amended the MSP provisions found at 42 U.S.C. 1395y(b). See 42 U.S.C.1395y(b)(7)&(8) which add separate mandatory reporting requirements for GHP arrangements and for non-GHP (liability insurance including self-insurance, no-fault insurance and workers' compensation). The following laws/regulations describe existing MSP information collection:

LAW/REGULATION	EFFECT
42 U.S.C. 1395y(b)(7)	Mandatory reporting requirements for GHP
42 U.S.C. 1395y(b)(8)	Mandatory reporting requirements for non-GHP (liability insurance including self-insurance, no-fault insurance and workers' compensation)
42 U.S.C. 1395y(b)(5)(D)	Prior to an individual's applying for benefits under Part A or enrolling in Part B, the Secretary is to mail a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of coverage under such a plan
42 U.S.C. 1395w-102(b)(4)(D)(ii)	Allows Part D plans and plan sponsors to ask beneficiaries about what other coverage they may have, and states that material misrepresentation of such coverage by the beneficiary is grounds for termination from Part D
42 CFR 411.25	If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must provide notice to that effect
42 CFR 489.20(f) and (g)	Provider (defined in 489.2(b)) agrees to maintain a system that identifies payers primary to Medicare during the admissions process and to bill other payers primary to Medicare except when the primary payer is a liability insurer

The following laws contain MSP amendments or implications:

LAW/REGULATION	EFFECT
Original Title XVIII of the Social Security Act	Medicare is secondary to Workers' Compensation (including Black Lung).
§ 953 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1980	Medicare is secondary to Automobile, Liability, and No-Fault coverage
COBRA 1981 § 2146 as amended	Medicare is secondary for beneficiaries with ESRD in their first 30 months of eligibility.
§ 116 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982	Medicare is secondary for working beneficiaries age 65 to 69 and their spouses age 65 to 69 who are covered by an Employer GHP
§ 2301 of the Deficit Reduction Act (DEFRA) of 1984	Medicare is secondary for beneficiaries age 65 to 69 regardless of working spouse's age
COBRA 1985 § 9201	Eliminates upper age limit of 69 for "working aged" MSP
COBRA 1986 § 9319	Medicare is secondary for disabled beneficiaries classified as "active individual" and covered by a Large GHP (LGHP)
COBRA 1987	Clarifies that COBRA 1986 applies to governmental entities
COBRA 1989	MSP uniformity provisions and IRS/SSA/CMS Data Match added
COBRA 1993	Changes basis of MSP for disabled beneficiaries from "active individual" to "current employment status"
MMA § 1860D-2(a)(4)	Applies MSP laws to the new Medicare Part D in the same manner as it applies to Part C (Medicare Advantage, formerly Medicare+ Choice)
§ 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173)	Mandatory reporting requirements for GHP arrangements and for Non-GHP (liability insurance including self- insurance, no-fault insurance and workers' compensation).

These laws create a continuing need for information collection so that Medicare makes payment in the proper order and takes recovery actions as appropriate.

2. Information Users

CMS contractors will assist in the administration of the reporting requirements of Section 111. This effort is frequently referred to as "Mandatory Insurer Reporting" (MIR). The applicable reporting entities will register on-line by logging on to a secure web site (currently under development) as a first step in complying with MIR. Once the applicable reporting entity submits its application via the secure website, CMS will begin working with the entity to set up the data reporting and response process.

CMS and its contractors will use this information to ensure that payment is made in the proper order and to pursue recovery activities.

3. Improved Information Technology (IT)

CMS continues to increase its use of IT applications to collect as much information electronically as it can using processes such as VDSAs. Many other routine development activities, such as the IEQ and various other developmental questionnaires are paper based, manual data collection processes. CMS is rapidly moving to convert from paper into electronic collection systems. Mandatory insurer reporting will be a 100 percent electronic reporting process, which will lead to a reduced need for other paper based routine development activities.

4. Duplication of Similar Information

These collection activities were created to reduce both burden and redundancy. Successful implementation of mandatory insurer reporting will allow CMS to eliminate or curtail other Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match.

5. Small Business

Even though relatively few small businesses will be impacted by this legislation, CMS has made efforts to minimize the burden that this collection of information will have on all submitting entities, including small businesses. Towards this end, CMS will make the application process completely electronic. The completion and submission of the MIR application will take place on-line via a CMS secure website (currently under development).

6. Collection Frequency

Collection will be on no more than a quarterly basis. GHP data will be submitted by the applicable reporting entity on an ongoing basis. Non-GHP data will be on an ongoing basis for no-fault insurance and workers' compensation for non-contested claims and on a one time basis for contested cases where there is a single settlement, judgment, award, or other payment.

Collecting information on a less frequent basis than is provided for in this submission will continue to create risk to the integrity of the Medicare trust funds. CMS has reduced duplicate or redundant MSP data collection by placing the responsibility of all MSP collections with one umbrella contractor, effective January 8, 2001.

7. Special Circumstances

Five years is generally recognized as the standard for record retention in the industry. However, CMS recommends a record retention period of ten years for MSP related information. CMS changed from "required ten years" to "recommend ten years" in the last MSP PRA Information Collection submission in July 2005. Absence of related information does not constitute a valid defense against an MSP recovery action.

Note: Administrative offset is permitted for 10 years. Additionally, False Claim Act actions can be brought for 10 years.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice published on _____.

CMS has established a separate MIR webpage for section 111 of the MMSEA and its implementation. Informational materials as well as instructions will be able to be downloaded from this webpage. The materials will include both draft and final documents, including information on how interested parties may comment on the documents and/or CMS' implementation of section 111. The web page can be found at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html.

Listening/Outreach Sessions

CMS conducted various listening and outreach sessions with GHP and non-GHP industry trade organizations that represent the majority of the insurance industry. Participants included: American Benefits Council, American Health Insurance Plan s, American Insurance Association, National Association of Insurance Commissioners, Physician Insurers Association of America, Society for Professional Benefits Administration and the American Bar Association's Joint Committee on Employee Benefits.

Concerns in the listening/outreach sessions included:

- Acquiring Social Security numbers
- How does a reporting entity ensure it is compliant

CMS will be holding additional listening sessions with affected groups and expects to hold open door forum calls. CMS has also established an email link for interested parties to sign up to receive email alerts when the webpage is updated. This link is available on the MIR webpage cited above.

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

Laws, regulations and guidance associated with the Health Insurance Portability Act (HIPAA) and the Privacy Act will apply to any information collected by CMS for purposes of this program.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these requirements.

12. Burden Estimate (hours and wages)

For both GHP and non-GHP situations, there has been a longstanding obligation to determine the correct order of payment and pay correctly. For example see 42 C.F.R.

411.25 and associated Federal Register General Notice published January 31, 1994 (Vol. 59, No. 20, Monday, January 31, 1994, p. 4285). Additionally, many of the data elements not required for coordination of benefit purposes are required for internal business purposes. Consequently, CMS does not believe that the collection of the required data elements will cause an undue burden although there may be effort involved in centralizing such information for reporting purposes.

Although CMS routinely collects SSNs from many reporting entities on a voluntary basis, for purposes of this Burden Estimate we are calculating the burden on the assumption that, in order to comply with the MIR requirements, the responsible reporting entities will have to solicit SSNs from all of their covered Medicare beneficiaries. The following calculations represent CMS' best estimate of its share of the paperwork burden regarding this collection. ***(See Attachment B – The Need for Social Security Numbers and/or Health Insurance Claim Numbers)***

GHP

The majority of GHP arrangements for which there is MSP involvement is already reported to CMS. We estimate that data for some seventy percent (70%) of all GHP covered lives is now received each calendar quarter by the CMS. For applicable reporting entities that have a VDSA, there will be little or no additional burden needed to submit the required GHP data.

New GHP applicable reporting entities will need to follow the existing and well established process leading to routine GHP MSP coordination of benefits as managed by the CMS Coordination of Benefit Contractor. Once a new GHP applicable reporting entity has registered with CMS, the common and readily available GHP data elements required ***(See Attachment C – GHP Data Elements)*** will be electronically submitted to CMS. Current VDSA partners report that, once established, the management of coordination of benefit data through this process is a routine business procedure.

Establishing the data exchange process initially takes, on average, the work of three employees five hours a day for 25 days, or a total of an average of 375 man hours. In addition, based on estimates developed for similar data web-based reporting processes that will be leveraged to implement MIR, for each entity we estimate an average of 2 hours administrative work to

assemble the applications. CMS estimates that approximately 2000 GHP entities will be required to report information to CMS under MIR.

CMS currently has 1.3 million GHP MSP records where the beneficiary has health insurance coverage through their employer. CMS has another 1.3 million GHP MSP records where the beneficiary is covered through their working spouse's health insurance coverage.

CMS estimates that it currently has GHP data on approximately 70 percent of beneficiaries where another GHP arrangement is primary to Medicare. Therefore, CMS estimates that the total reporting burden for GHP arrangements will be on 3.7 million covered lives.

SSN Collection: 5 minutes x 3.7 million = 308,334 hours x $12/hour = $3,700,008 System Set-Up Costs: 375 hours x 2000 = 750,000 hours x $12/hour = $9,000,000 Ongoing Administrative Burden = 2 hours/response x 2000 responses = 4000 hours

Total GHP burden = 308,334 hours + 750,000 hours + 4000 hours = 1,062,334 hours

Non-GHPs

For most non-GHPS, gathering the data required for MIR will not be a considerable burden. Because the applicable reporting entities have had a long-standing obligation to coordinate claims payment with the Medicare program and to pay clams for health care in the proper order, CMS must assume the Non-GHP entities currently collect the data required for reporting. In addition, we do not believe the effect of the initial burden of MIR will be very laborious since Non-GHP entities payers have needed the data in order to properly conduct their own business operations.

Non-GHP entities not now reporting to CMS on a regular basis will need to adopt the reporting methodology developed for them by CMS. Once a Non-GHP applicable reporting entity has registered with CMS, the common and readily available non-GHP data elements ***(see Attachment C- Non-GHP)*** will be electronically submitted to CMS. Reporting for contested claims which have been resolved through a single settlement, judgment, award, or other payment will be a one-time occurrence. For Non-GHP entities reporting ongoing payment information requiring coordination of benefit follow-up, ongoing management of coordination of benefit data through the established reporting process will be a routine business procedure. Current VDSA partners report that, once established, the management of coordination of benefit data through this process is a routine business procedure. For those required reporting entities that will have to establish routine reporting to CMS, establishing the data exchange process initially takes, on average, the work of three employees five hours a day for 25 days, or a total of an average of 375 man hours. In addition, based on estimates developed for similar data web-based reporting processes that will be leveraged to implement MIR, for each entity we estimate an average of 2 hours administrative work to assemble the applications. CMS estimates that approximately 400 non-GHP entities will be required to report information to CMS under MIR on an ongoing basis. CMS estimates that there are approximately 2.9 million non-GHP claims made annually by Medicare beneficiaries that may or may not be settled. For purposes of this estimate, CMS assumes that all will be settled and reported to CMS under the MIR program. CMS assumes 90 percent will be reported by the approximately 400 non-GHP entities that will be required to report information to CMS on an ongoing basis and that 10 percent will report on an as needed

basis through direct data entry via the internet and that, based on other similar Coordination of Benefit Contractor reporting processes, reporting time for direct data entry will be 18 minutes per record.

SSN Collection: 5 minutes x 2,926,100 = 243,841 hours x $12/hour = $2,926,092 Combined System & Administrative:

(375 hours x 400 = 150,000 hours x $12/hour = $1,800,000) +

(2.3 hours x 288,827 = 664,302 x $12/hour = $7,971,624) equals $9,771,624

Total non-GHP burden = 243,841 hours + 150,000 + 664,302 hours = 1,058,143 hours

The average burden for completing MIR includes time taken to: 1) review the instructions, 2) search for and compile the needed data, and 3) complete the report.

The burden for completing MIR is primarily dependent upon the number of individuals for whom an insurer must report information. Other influencing factors may be:

- the accessibility and format of personnel and health plan(s) records;
- the number of GHPs offered by an organization;
- the frequency of changes between plans or in coverage elections; and
- the format the insurer uses in responding to the collection activity.

This burden can be attributed to insurer familiarity with the reporting process, data required on fewer covered individuals and for more current periods of time, enhancements to the reporting system, and clarifications made to the instructional materials that address insurer questions or concerns.

13. Capital Costs

There are no capital costs. We have assumed that all required reporting entities will own at least one computer and have access to the internet.

14. Cost to Federal Government

Once implemented, CMS estimates that annual ongoing maintenance and support costs for this activity will be $8 million per year.

15. Program Changes/Changes in Burden

This is a new information collection request; however, as stated under item 4 of this document, these collection activities were created to reduce both burden and redundancy. Successful implementation of mandatory insurer reporting will allow CMS to eliminate or curtail other Coordination of Benefit Contractor data collection processes such as the IRS/SSA/CMS Data Match.

16. Publication and Tabulation

There are no plans to publish or tabulate the information collected for statistical use.

17. Expiration Date

We request that this requirement be excepted. Due to the ongoing nature of this collection, we do not believe a reference to an expiration date is in the best interest of this collection. The omission of the expiration date will obviate the necessity to reprogram our systems each time OMB extends approval for MSP data collection.

18. Certification Statement

There are no exceptions to the certification statement.

C. Statistical Methods

This collection of information does not employ statistical methods.

Attachment A: Definitions and Reporting Responsibilities

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

DEFINITIONS AND REPORTING RESPONSIBILITIES

GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)) --

INSURER

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

THIRD PARTY ADMINISTRATOR (TPA)

For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7):

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of :

- Insurers for GHPs
- TPAs for GHPs
- Employers with self-insured and self-administered GHPs

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

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

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

INSURER

For purposes of the reporting requirements for 42 U.S.C. 1395y(b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

CLAIMANT:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".

APPLICABLE PLAN:

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)((F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, or self-insured employer or the employer's insurer.

NO-FAULT INSURANCE:

Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.

LIABILITY SELF-INSURANCE:

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

SPECIAL CONSIDERATIONS WHERE LIABILTY SELF-INSURANCE WHICH IS A DEDUCTIBLE OR CO-PAYMENT FOR LIABILTY INSURANCE, NO- FAULT INSURANCE, OR WORKERS' COMPENSATION IS PAID TO THE INSURER OR WORKERS' COMPENSATION ENTITY FOR DISTRIBUTION (RATHER THAN DIRECTLY TO THE CLAIMANT):

As indicated in the definition of "liability self-insurance," such deductibles and co- payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two entities reporting with possible confusion where the deductibles and/or co-payments are physically being paid by the insurer or its TPA, CMS is considering requiring such deductibles and co-payments to be reported as part of the insurer or TPA's report.

CMS specifically seeks comments on this approach. If this approach is not adopted, both entities will have to report in this situation. Regardless of the final decision on this approach, CMS may need to add a few additional data elements (in the form of a question or otherwise) so that it will clearly be able to identify such situations.

WORKERS' COMPENSATION LAW OR PLAN

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

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

Agents may submit reports on behalf of:

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

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

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

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

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

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

The SSN is used as the basis for the HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet it administrative responsibilities to pay for health care and operate the Medicare program. Pursuant to 42 U.S.C. 1395y(b), Medicare is the secondary payer to GHP coverage under certain circumstances and to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The SSN or HICN is the cornerstone of the administration of the Medicare program. Medicare uses an individual's SSN or HICN to ensure that Medicare makes payment in the proper order and/or takes the necessary recovery actions. Absent the SSN or HICN, CMS would not be able to systematically link the reported data to a particular Medicare beneficiary.

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

We also note that there are some state laws that restrict when SSNs can be collected and how SSNs can be used. These state initiatives do not preempt the MSP statutory or regulatory provisions or the "permitted use" provisions of the HIPPA privacy rules.

These referenced federal laws allow for the collection and use of the SSNs to help providers and insurers manage their operations. Some states now restrict how SSNs may be displayed, such as prohibiting a health plan from including an SSN on an individual's plan ID card. Such state laws are permissible, to the extent they augment but do not conflict with or constrain the requirements of federal laws or regulations.

Attachment C: GHP Data Elements

INSURER GHP

DATA SHARING INPUT FILE

Required Data Elements

1. HIC number (HICN; Medicare ID Number)
2. Beneficiary SSN (Required if HICN Not Available)
3. Beneficiary surname (First five letters required)
4. Beneficiary First Initial
5. Beneficiary Date of Birth
6. Beneficiary Sex Code
7. Document Control Number (Assigned by the insurer)
8. Transaction Type (Add, Delete or Update)
9. Coverage Type (Type of insurance coverage)
10. Effective Date (Effective date of current coverage)
11. Termination Date (Termination date of current coverage)
12. Relationship Code (Relationship to policy holder)
13. Policy Holder's First Name
14. Policy Holder's Last Name
15. Policy Holder's Social Security Number
16. Employer Size
17. Small Employer MSP Exception
18. Group Policy Number
19. Individual Policy Number
20. Employee Coverage Election (Who the policy covers)
21. Employee Status (Reason why GHP is primary)
22. Employer EIN and Business Address
23. Insurer EIN and Business Address

Additional Data Elements – Optional

Elements 24-27 are the "Four Rx" elements needed for reporting prescription drug coverage.

24. Rx Insured ID Number
25. Rx Group Number
26. Rx PCN
27. Rx BIN Number
28. Rx Toll Free Number (To call with questions regarding Rx coverage)
29. Person Code (Assigned by Insurer)

Attachment D: NGHP Data Elements

Non-GHP

Data Elements Input File

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

1.	Last Name	(Mandatory)
2.	First Name	(Mandatory)
3.	Middle Initial	(Optional)
4.	Address	(Mandatory)
5.	Telephone	(Optional)
6.	Email	(Optional)
7.	Date of Birth	(Mandatory)
8.	Date of Death	(Situational)
9.	Gender	(Mandatory)
10.	Social Security Number	(Situational) ***[Mandatory if HICN not provided, pseudo SSNs not permitted]***
11.	Beneficiary HICN	(Situational) ***[Mandatory if SSN not provided Pseudo HICNs not permitted]***

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

[All items noted as situational, only needed when claimant no the Injured Party]

12.	Beneficiary Relationship	(Situational) ***[Estate/Spouse/Child/Sibling or Other]***
13.	Name and Address	(Situational)
14.	Telephone and/or Email	(Optional)
15.	TIN [SSN or EIN]	(Situational) ***[Pseudo SSNs or EINs not permitted]***

Primary Plan [Separate Report for Each Plan and/or Insurance Type]

[If settlement for more than two individuals must report separately]

16.	Insurance Type	(Mandatory) ***[Workers' Compensation, Liability or No-Fault]***
17.	Name	(Mandatory) ***[Legal Name]***
18.	Address	(Mandatory)
19.	TIN [SSN or EIN]	(Mandatory) ***[Pseudo SSNs or EINs not permitted]***

20. Additional Information (Optional)

21. Policy Number (Mandatory)

22. Claim Number (Mandatory)
[Internal claim number]

23. No fault Policy Limit (Situational)
[In No-Fault]

24. Exhaust Information (Situational)
[In No-Fault; Report date only if benefits are fully exhausted]

Policy Holder

25. Policy Holder Name – Legal Name (Mandatory)

26. Policy Holder Name – DBA Name (Mandatory)
[May or may not be the same as legal name]

27. Self-Insured (Mandatory)
[Yes or No? Applies to WC and Liability. See supporting document for full explanation of the term "liability self-insurance."]

Injured Party or Claimant Attorney/Representative

[All items noted as situational applicable when there is an Attorney]

28. Attorney Name (Situational)

29. Firm Name (Situational)

30. Attorney Address (Situational)

31. Attorney Telephone and/or Email (Optional)

32. "Attorney" TIN [SSN or EIN] (Situational)
[Pseudo SSNs or EINs not permitted; TIN for individual attorney or firm dependent on which is listed as a payee]

33. State Bar Member Number and State (Optional)

Incident

34. Date of Injury (Mandatory)
[For an automobile wreck or other accident, the DOI is the date of the accident. For claims involving exposure, the DOI is the date of first exposure. For claims involving ingestion (for example a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).]

35. Nature of Injury (Situational)
[WCIO Nature of Injury Table]

36. Cause of Injury (Situational)
[WCIO Cause of Injury Table]

37. State of Venue (Mandatory)

38. ICD-9 Code [Up to 5 occurrences] (Situational)

[At least 1 ICD-9 Code or Body Part Code]

39. Body Part [Up to 5 occurrences] (Situational)

[WCIO Body Part Code Table; At least 1 Body Part Code or ICD-9 Code]

40. Product Liability (Mandatory)

[Yes or No]

41. Product Liability Information (Situational)

[If #43 is yes, provide Product generic name, brand name and manufacturer. Also describe alleged harm (free form space provided)]

Resolution

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

42. Settlement Date (Situational)

[Date of Settlement, Judgment, Award or Other payment]

43. Amount (Situational)

[Amount of Settlement, Judgment or Award]

44. Claim Resolution (Mandatory)

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

45. Funding (Situational)

[Was funding of the settlement, judgment, award or other payment contingent upon proof of resolution of Medicare's fee for service Medicare Secondary Payer recovery claim? Yes or No.]