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Centers for Medicare & Medicaid Services
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Center for Consumer Information and Insurance Oversight

Medicare Periodic Data Matching (PDM) – External Frequently Asked Questions (FAQ)

Q1. What is Medicare Periodic Data Matching (PDM)?

A1: As described in Health Insurance Exchange regulations at 45 CFR 155.330(d)(1)(ii), Medicare PDM includes the process by which Health Insurance Exchanges (also referred to as the Exchange or Marketplace) periodically examine available data sources to identify consumers enrolled in Exchange health plans with financial help at the same time they're determined eligible for or enrolled in Medicare Part A (Hospital Insurance) or Medicare Part C (Medicare Advantage), which are considered qualifying coverage (also known as Minimum Essential Coverage or MEC.)[1] Financial help includes advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR), which help pay for Exchange plan premiums and covered services. The Exchange (for purposes of this document, this generally refers to Health Insurance Exchanges that use the federal eligibility and enrollment platform) notifies these consumers that:

- Their Exchange coverage may duplicate benefits they already get through Medicare.
- They may benefit from ending their Exchange coverage.
- They don't qualify for APTC or CSR for Exchange coverage after they are considered eligible for Medicare that is MEC.

Q2: Why will this Medicare PDM notice be sent to consumers?

A2: Consumers must take action if they're eligible for or enrolled in qualifying coverage (also known as Minimum Essential Coverage, or MEC) through Medicare Part A (whether or not they are enrolled in a Medicare Advantage plan under Medicare Part C), and an Exchange plan with financial help. In those cases, they must end their financial assistance through the Exchange because they're not eligible for APTC/CSR for Exchange coverage after they became eligible for benefits under Medicare Part A, which is considered MEC. If they don't take this step, the household's tax filer(s) will likely have to pay back all or some of the APTC paid to the health

[1] Medicare Part A and Part C are considered MEC; some forms of Medicare coverage (e.g. Medicare Part B only and Part D only) are not considered MEC.

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plan on the consumer's behalf for Exchange coverage after they are considered eligible for or enrolled in Medicare Part A.

Note: Consumers who have to pay a premium for Medicare Part A (because they're not entitled to premium-free Part A), should compare their Exchange plan costs with their Medicare benefits and total premiums (including Medicare Part A and Medicare Part B, and, as applicable Medicare Part C, as well as Medicare Part D). They can choose to end their Medicare coverage and if they do so, they can remain enrolled in an Exchange plan, with or without APTC/CSR.

Consumers entitled to or enrolled in Medicare Part A without a premium (including if enrolled in a Part C plan, which can also be known as a "Medicare Advantage plan") can also end all of their Medicare coverage to become eligible for Exchange financial help, but this option would be much more costly and would require the beneficiary to pay back all Social Security and Medicare benefits previously received to the government. In order to keep their Exchange financial help the consumer would also have to give up future Medicare and Social Security benefits. In addition, this may also result in Medicare late enrollment penalties if the consumer enrolls in Medicare at a later time. Consumers can contact Social Security for more information by visiting socialsecurity.gov, going to a local Social Security office, or calling Social Security directly at 1-800-772-1213 (TTY: 1-800-325-0778).

Q3: Who will receive a Medicare PDM notice?

A3: The Exchange will conduct a data match against the Centers for Medicare & Medicaid Services' (CMS) internal Medicare enrollment databases to determine if consumers who are enrolled in Exchange coverage with APTC/CSR are also eligible for or enrolled in Medicare Part A or Medicare Part C. The consumers for whom a data match will be conducted are all those enrolled in Exchange coverage with APTC/CSR who have a Social Security Number that has been successfully validated by Social Security. The Exchange will generate one Medicare PDM notice per affected tax household. The notice identifies all affected consumers for the household's Exchange application and includes instructions for required next steps. The notice will be addressed to the household's primary contact and posted in their online Marketplace account or sent to the primary contact by mail, depending on the primary contact's preference listed in their Marketplace account at the time of initial application or application updates by the consumer.

Q4. Which parts of Medicare are considered Minimum Essential Coverage or MEC?

A4: Medicare Part A and Medicare Part C are both considered MEC; however, if a consumer would be required to pay a premium for Medicare Part A (because they are not entitled to premium-free Medicare Part A), such coverage will be considered MEC only if the consumer is actually enrolled in Medicare Part A. If such a consumer opts not to enroll in Medicare Part A,

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they may still be eligible for APTC or CSR to help pay for an Exchange plan premium and covered services. A consumer who's eligible for premium-free Medicare Part A isn't eligible for APTC or CSR to help pay for an Exchange plan premium and covered services, regardless of whether the consumer actually enrolls in Medicare Part A. Since Medicare Part C (Medicare Advantage) is also considered MEC, a consumer who is enrolled in a Medicare Advantage Plan isn't eligible for APTC or CSR to help pay for an Exchange plan premium and covered services.

Q5: How is a consumer determined eligible for Medicare? Are consumers ever automatically enrolled into Medicare?

A5: Consumers may become entitled to Medicare while enrolled in an Exchange plan with or without APTC/CSR for several reasons, including aging into Medicare (i.e., turning age 65), reaching the 25th month of disability, or being diagnosed with certain diseases that permit Medicare enrollment (Lou Gehrig's disease or End-Stage Renal Disease). A consumer who's getting Social Security benefits at least 4 months prior to their 65th birthday will be automatically enrolled in premium-free Medicare Part A and in Part B (consumers are responsible for paying the monthly Medicare Part B premium, and have a right to opt out of Medicare Part B). Additionally, consumers who reach their 25th month of disability and are receiving Social Security disability benefits will also be automatically enrolled in premium-free Medicare Part A and in Part B. Other consumers who are eligible for Medicare, but are not automatically enrolled for any of the reasons listed above, must submit an application to enroll in Medicare Part A and Part B through Social Security. For more information on Medicare eligibility and enrollment, visit Medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b.

Q6. What are the impacts to a consumer's premium if they're dually-enrolled in Medicare and Exchange coverage? Does it matter if they also get APTC?

A6: There is no impact to the Exchange plan premium itself. However, when a consumer is considered eligible for Medicare (Part A or Part C) and is enrolled in an Exchange health plan, they don't qualify for advance payments of the premium tax credit (APTC) to help reduce their monthly payment (they also do not qualify for cost-sharing reductions (CSR)to help with paying for covered services), and they'll have to pay the full cost of the Exchange health plan premium and covered services for Exchange coverage after they are considered eligible for Medicare that is Minimum Essential Coverage (MEC). Additionally, when they file their federal income taxes, the household's tax filer may have to repay all or some of the APTC paid to the health plan on the consumer's behalf for Exchange coverage after they were considered eligible for Medicare that is MEC. Finally, consumers should contact their issuer for information about how Coordination of Benefits rules may apply.

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Q7: Can a consumer age 65 and receiving Social Security benefits decline Medicare Part A and only enroll in Medicare Part B?

A7: A consumer who's getting Social Security benefits before the individual turns 65 will automatically be enrolled in premium-free Medicare Part A and in Medicare Part B on the first day of the month in which they turn 65. This occurs because the consumer 1) is already getting Social Security benefits, and 2) has aged into Medicare, and 3) is eligible for premium-free Medicare Part A.
In this case, the consumer can't decline his or her entitlement to Medicare Part A without withdrawing their application for benefits from Social Security, paying back all Social Security and Medicare benefit amounts previously provided. If the individual were to take these steps, however, the individual could apply for Medicare Part B using CMS-4040 form as described in 42 C.F.R. 407.11.

Q8: How did Medicare PDM change after 2019?

A8: Prior to 2019, Medicare PDM was a resource-intensive manual process. It didn't allow for the Exchange to end APTC/CSR for consumers found dually-enrolled in Medicare and an Exchange health plan. CMS initiated information technology (IT) functionality in 2018 that, since 2019, allows the Exchange to take action and end a consumer's APTC/CSR if they're found to be dually enrolled in Medicare and an Exchange health plan. Currently, the Exchange ends Exchange health plan coverage for consumers who provide written consent to the Exchange, on their application for Exchange coverage via an attestation question, to take this action if they're found to be dually enrolled at a later date. Based on the primary contact's preference, as written on the application, the Exchange either posts the Medicare PDM notice to the consumer's online Marketplace account or mails it to the consumer's primary address depending on the consumer's preference set at initial application or during application updates. Impacted consumers have 30 days from the date the notice is sent to respond to the Exchange's notice. For consumers who do not respond to the notice, the Exchange ends APTC/CSR and/or Exchange plan coverage, depending on what the consumer elected when applying, after the 30-day window elapses.

Q9: How often will the Exchange send the Medicare PDM notice?

A9: Per the Exchange Program Integrity Rule (CMS-9922-F) published in the Federal Register on December 27, 2019 (84 FR 71674), all Exchanges are required to conduct Medicare PDM at least twice per year beginning on January 1, 2021. CMS expects the Exchange to send Medicare PDM notices approximately 4 times per calendar year to ensure that consumers receive timely notification of their dual enrollment status. However, the frequency will depend on various factors, including evaluations of previous rounds of Medicare PDM.

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Q10. How can consumers avoid financial penalties for late enrollment in Medicare Part B?

A10: In most cases, if an individual does not sign up for Medicare Part B when he or she is first eligible, the individual will have to pay a late enrollment penalty. Consumers can avoid financial penalties for Medicare Part B by signing up during his or her "Initial Enrollment Period". If an individual is eligible (also called "entitled") to Medicare Part A and/or Medicare Part B based on turning age 65, the Initial Enrollment Period is the 7-month period that begins 3 months before the month the individual turns 65, includes the month the individual turns 65, and ends 3 months after the month the individual turns 65. For an individual under age 65 who becomes entitled to Medicare based on disability, entitlement begins with the 25th month of disability benefit entitlement. For these individuals, the Initial Enrollment Period begins 3 months before the 25th month of disability benefit entitlement, includes the 25th month, and ends three months after. The Initial Enrollment Period for individuals with ESRD and ALS varies based on their situation.

In certain other limited situations, an individual may not have to pay a Part B late enrollment penalty if he or she signs up during a Special Enrollment Period. For more information on Parts A and B enrollment periods and eligibility, please visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If an individual does not sign up for Medicare Part A (in the case of individuals who would have to pay a premium for it) and/or Medicare Part B (for which individuals must pay premiums) during his or her Initial Enrollment Period, and he or she doesn't qualify for a Special Enrollment Period, the individual can sign up between January 1 and March 31 each year. This is called the General Enrollment Period. If the individual signs up during the General Enrollment Period between January 1 and March 31, his or her coverage won't start until July 1 of that year, and the individual may have to pay a higher Medicare Part A and/or Medicare Part B premium (for late enrollment penalties). The late enrollment penalty for Part B applies the entire time the individual has Part B coverage but the late enrollment penalty for Part A (If the individual as to buy it) can be phased out after the individual has been covered under Part A and paying a premium for twice as long as he or she delayed signing up.

Consumers should contact Social Security to request enrollment in Medicare Part A and/or Medicare Part B.

Q11. Can certain dually-enrolled consumers still petition Social Security for relief to avoid financial penalties if they want to enroll in Medicare Part B?

A11: For a limited time, the Medicare PDM notice informed consumers of the potential for "equitable relief," which was available for certain consumers dually enrolled Medicare and an Exchange health plan on or before June 30, 2020. This relief, which provided eligible consumers

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with an opportunity to enroll in Medicare Part B without a late enrollment penalty, is only available for individuals who met the eligibility criteria, described below, by June 30, 2020. While this relief is not available to consumers identified as dually enrolled after June 30, 2020, consumers meeting the criteria outlined below can still contact Social Security to request enrollment in Medicare Part B or a penalty reduction for late enrollment in Medicare Part B. When they make their request, consumers will need to bring a copy of their Medicare PDM notice in person to the Social Security office.

This relief will continue to be considered on a case-by-case basis for current or previously dually enrolled beneficiaries. To be eligible for the relief, the consumer must provide evidence of dual enrollment, be enrolled in premium-free Medicare Part A, **AND**:

- Have a Part A entitlement date between July 2013 and June 2020, OR
- Have been notified by Social Security of retroactive Part A entitlement between October 1, 2013 and June 30, 2020, OR
- Have a Part B Special Enrollment Period that ended between October 1, 2013 and June 30, 2020.

Q12. Why is CMS expanding its outreach efforts?

A12: CMS expanded outreach so that consumers receive information from CMS about the risks of delayed enrollment in Medicare Part B. CMS updated Medicare enrollment communications to these consumers, to include additional information about the risks of continuing individual Exchange health plan coverage at the same time they're enrolled in Medicare. While these efforts are underway, CMS is continuously working to ensure that dually-enrolled consumers in both Medicare and an Exchange plan have the information to make informed choices about Part B enrollment and also understand how coverage transitions from the Exchange to Medicare. As such, since the beginning of 2020, CMS has been sending out monthly notices to Exchange enrollees turning 65 to ensure they know they might be eligible for Medicare. This notice also provides information on Medicare enrollment timelines, the consequences of dual enrollment, and how to end their Exchange plan coverage once they become enrolled in Medicare.

Q13: Can a consumer appeal if they believe they're still eligible for financial assistance (i.e., APTC/CSR) or that their Exchange plan coverage was incorrectly terminated?

A13: Yes. Consumers who believe that the Exchange erroneously ended their APTC/CSR or Exchange plan coverage, may submit an appeal to the Department of Health & Human Services (HHS) appeals entity, which is referred to as the Marketplace Appeals Center. Consumers will receive an updated Eligibility Determination Notice that provides instructions on how to appeal the action that the Exchange will be taking, specifically, ending APTC/CSR or Exchange plan coverage.

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