An Independent Licensee of the Blue Cross and
Blue Shield Association

MEDICARE COMPLIANCE

The purpose of this communication is to notify employers of the mandatory reporting requirements of the Medicare, Medicaid, and SCHIP Extension Act of 2007 which were passed into law in July 2008. Your cooperation in providing the necessary employer data and data for each employee and dependent is needed in order to comply with the requirements.

The Section 111 mandates of the law help payers identify when the Centers for Medicare and Medicaid Services (CMS) should pay secondary to employer group health coverage. The goal includes reducing the amount CMS may pay as primary when they should have paid as secondary.

Under the requirements, all health plan, liability, no fault and workers compensation coverages must register with CMS as a Responsible Reporting Entity (RRE) and must report to CMS employer and member information. In order to fulfill the mandated requirements and report accurately to CMS, Wellmark, as a RRE, must gather and groups must provide the following information:

- Employer Tax Identification Number (ETIN)
- Evidence of status as a Commonly Owned/Controlled Group of Organizations, Multi/Multiple Employer Group health plan (such as an Association or Trust), Hour Bank or Union health plan
- Total number of group employees/group size
- Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs) of active employees, spouses, domestic partners
- SSNs or HICNs for those dependents with end stage renal disease (ESRD) or disabled
- Status of all employees and effective date of that status (i.e. active, COBRA, retired)
- Disability information begin or end dates, if known

Please take a moment to complete the Confirmation of Medicare Secondary Payer (MSP) Addendum form. This will allow us to capture your employer data for reporting to CMS. Member data is gathered through the use of the group's existing enrollment and eligibility data collection channels, which may include paper applications or electronic data exchanges and should be provided through those processes.

Failure to provide the group information requested on the attached Confirmation of MSP Addendum can result in penalties being assessed to the group including, but not limited to, $1,000 per day per member for not accurately reporting to CMS and/or an excise tax equivalent to 25 percent of the employer's group health plan expenses for the relevant year.

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FOR ADMINISTRATIVE USE ONLY
New Group: Group # ________________________
Coverage Effective Date: ______/______/______

CONFIRMATION OF MSP ADDENDUM

ALL NEW AND RENEWAL GROUPS ARE REQUIRED TO SUBMIT A COMPLETED FORM. FAILURE TO SUBMIT A COMPLETED FORM WILL DELAY THE INITIAL ENROLLMENT OR RENEWAL PROCESS UNTIL THIS FORM IS SUBMITTED.

Part A - Employer Information

Please complete a separate confirmation form for each Employer Tax Identification Number you use to report employee earnings to the Internal Revenue Service (IRS). See the Medicare Secondary Payer Definitions page (M-1756) for more information on terms shown in italics.

Employer Tax Identification Number: ☐☐☐☐☐☐☐☐☐

Group Number (Renewing Groups Only): ________________________

Employer Name: ________________________

Employer Address: ________________________

City: ________________________ State: ____________ Zip: ____________

Contact Person: ________________________

Telephone Number: ________________________ E-mail Address (optional): ________________________

1. Did your organization make contributions on behalf of any employee who was covered under a *collectively bargained Health and Welfare Fund* (i.e., union plan) during the previous calendar year? ☐ Yes ☐ No
2. Did you have 20 or more *employees* for 20 or more calendar weeks (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous or current calendar year? If no, in the event you experience a change, you must notify Wellmark when this change occurs. ☐ Yes ☐ No
3. Did you have 100 or more *employees* during 50 percent of your business days (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous calendar year? ☐ Yes ☐ No
4. Did your organization participate in a *multi* or *multiple employer group health plan* (more than one employer in group, i.e., Multiple Employer Welfare Association) during the previous calendar year? ☐ Yes ☐ No

   If yes, what is the name and address of the *multi* or *multiple employer plan?*

   Name: ________________________

   Address: ________________________

   City: ________________ State: __________ Zip: __________
5. Was your organization part of a commonly owned or commonly controlled group of organizations during the previous calendar year? ☐ Yes ☐ No

   If yes, what is the name and address of the *commonly owned/controlled entity?*

Name: ________________________
Address: ________________________
City: ____________ State: ______ Zip: ______

Name: ________________________
Address: ________________________
City: ____________ State: ______ Zip: ______

Part B - Employer Certification

I certify that the information provided is accurate and truthful. All information will be used to identify the *Medicare Secondary Payer* status of *Medicare*-enrolled *employees.*

____ ______/______/______

Signature Date

Send completed MSP form based on following:			
IA & SD Large Groups (new or renewal)	IA & SD Small Groups (new or renewing with benefit changes)	IA Small Groups renewing with no benefit change - send this form to:	SD Small Groups renewing with no benefit change
Submit this completed MSP form with group's health plan new or renewal paperwork	Submit this completed MSP form with group's health plan new or renewal paperwork	Fax: (515) 376-9044 or Wellmark, Inc. PO Box 9232 – Mail Station 3W396 Des Moines, IA 50306-9232	Send this completed MSP form to: Wellmark, Inc. PO Box 5023 – Station 338 Sioux Falls, SD 57117-5023