



Office of Financial Management/Financial Services Group

June 11, 2008

Statutory Language
for the Medicare Secondary Payer Mandatory Reporting Provisions in
Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
(See 42 U.S.C. 1395y(b)(7)&(b)(8))

SEC. 111. MEDICARE SECONDARY PAYOR.

(a) In General- Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

 (7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS-

 (A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

 (i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

 (ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

 (B) ENFORCEMENT-

 (i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of \$1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A 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). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

 (ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

 (C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

 (i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

 (ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

 (iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

 (D) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

“(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS’ COMPENSATION LAWS AND PLANS-

“(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall--

“(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

“(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

“(B) REQUIRED INFORMATION- The information described in this subparagraph is--

“(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

“(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

“(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

“(D) CLAIMANT- For purposes of subparagraph (A), the term ‘claimant’ includes--

“(i) an individual filing a claim directly against the applicable plan; and

“(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

“(E) ENFORCEMENT-

“(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A 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). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

“(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

“(F) APPLICABLE PLAN- In this paragraph, the term ‘applicable plan’ means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

“(i) Liability insurance (including self-insurance).

“(ii) No fault insurance.

“(iii) Workers’ compensation laws or plans.

“(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

“(H) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.’.

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of

\$35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.



Office of Financial Management/Financial Services Group

DATE: June 23, 2008

SUBJECT: Collection of Social Security Numbers (SSNs), Medicare Health Insurance Claim Numbers (HICNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT

This ALERT is to advise that collection of SSNs, HICNs, or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.

SSNs and EINs:

- The SSN is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. Please note that The Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting SSNs or HICNs for coordination of benefit purposes.
- The EIN is the standard unique employer identifier. It appears on the employee's federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses. The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers' compensation laws or plans. Two key elements that will be required to be reported are SSNs (or HICNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a group health plan arrangement, your SSN and/or HICN will likely be requested in order to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning their SSN and/or HICN and whether or not they (or the injured party, if the settlement, judgment or award is based upon an injury to someone else) are Medicare beneficiaries. Employers, insurers, third party administrators, etc. will be asked for EINs.

To confirm that this ALERT is an official Government document and for further information on the mandatory reporting requirements under this law, please visit the CMS website at www.cms.hhs.gov/MandatoryInsRep.