INSTRUCTIONS - COMPLETING THE ANNUAL MSP EMPLOYER ACKNOWLEDGEMENT FORM

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Important Note

Under federal law, it is the employer's responsibility to annually inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered **primary to Medicare**.

Background
When an individual is covered by both Medicare and an employer's group health plan (GHP), Medicare secondary payer (MSP) rules specify that the employer's total size, not group health plan enrollment size, is a factor in determining whether Medicare benefits are primary or secondary. Employer size is a factor in MSP order of payment determinations when the covered individual is Medicare-entitled due to either age ("working aged") or disability.

Employer information — Who is the Employer?
For MSP purposes, the employer is the legal entity that employs the employees. For example, the employer may be an individual, a partnership, or a corporation. In some situations, it may not be clear which corporation or individual is the employer for MSP purposes. In these cases, employers must use Internal Revenue Service aggregation rules provided in the Internal Revenue Code [IRC 26 U.S.C. Sections 52(a), 52(b), 414(n) (2)]. In general, these rules specify that single employers include

- all employees of all corporations that are members of the same controlled group of corporations, and
- all employees of trades or business (whether incorporated or not), e.g., employees of partnerships, LLCs, proprietorships that are under common control.

The Centers for Medicare & Medicaid Service's (CMS) *MSP Manual* provides additional guidance about aggregation for affiliated service groups and religious orders, as well as authoritative information about employer size and other MSP topics. The *MSP Manual* is available online at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Question 1 — Did you file a separate Federal Tax Return?
If you filed a federal tax return that did not include information about any other individual or entity, check "Yes." If you filed a federal tax return consolidated with another individual or entity, check "No." If you are not required to file a federal tax return, check "N/A."

Question 2 — Employer Size from Your Federal Tax Return Information
How many employees did all the entities listed on the tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the prior calendar year? It is important that you enter the total number of employees for all entities (including parent, subsidiaries and affiliated entities) listed on the tax return, since this may determine whether or not Medicare will be the primary payer of claims. Subsidiaries of foreign companies must count the number of employees of the organization worldwide.

Question 3 — Are you part of a multi-employer group health plan?
Authoritative guidance for determining multiple employer group health plan participation can be found in the Code of Federal Regulations at 29 CFR § 2510.3-37

Questions 4 and 5 — Working Aged Rule & Employer Size
Under the MSP "working aged" rule, Medicare is secondary to the employer's GHP coverage if the employer's size equals 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. *(Question 4 refers to this standard as "the threshold.")* Note: the year of your upcoming renewal is the 'current' year. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes. This also applies to multi-employer and multiple employer group health plans in which at least one employer employs 20 or more employees.

- *Counting individuals for the "20-or-more" employer size*
  - Employees counted in the 20-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or who are expected to report for work on a particular day.
  - Those not counted in the 20-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.

The information in these instructions should not be construed as legal advice or as a legal opinion on any specific facts or circumstances, and is not intended to replace advice of independent legal counsel.

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- *Employer size increases to 20 or more during the year*

  If the employer's size was below 20 during the preceding year, the employer's GHP coverage becomes primary as soon as the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The 20 calendar weeks do not have be consecutive. Then, the employer's GHP coverage is primary for the remainder of the year and during the following year.

  For example, the employer's size meets the 20-or-more employee threshold as of Oct. 1, 2009. The employer's GHP coverage becomes primary for services provided from Oct. 1, 2009 through December 31, 2010.

Please note: If you check "No" for the current year in EAF **Question 4** and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF and indicating the date the change occurred in the space provided in **Question 4**.

- *Employer size fails to meet the threshold of '20 or more employees during 20 or more weeks' during the year*

  If the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks for the preceding year, but during the current calendar year the employer size never meets that threshold, the employer's group health plan remains primary until the end of the current year.

  For example, during 2009 the employer's size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks. However, during 2010 the employer's size never meets this threshold. The employer's group health plan coverage remains primary through December 31, 2010.

- *Individuals affected by the working aged rule*

  The "working aged rule" applies to individuals who are Medicare-entitled due to age (age-65 or older) and

  - Are covered under their employer's GHP and have "current employment status" and the employer meets the "20-or-more" employer size requirements (above), or
  - Are covered under their spouse's (of any age) employer's GHP and the spouse has current employment status and the employer meets the "20-or-more" employer size requirements (above).

Questions 6 and 7 — Disability Rule & Employer Size

Under the MSP "disability" rule, Medicare benefits are secondary to an employer's large group health plan (LGHP) benefits when the employer size equals 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days during the previous calendar year. The business days do not have to be consecutive.

If the plan is a multi-employer plan, Medicare is the secondary payer for individuals enrolled in the plan as long as at least one of the employers meets the 100-or-more employee threshold.

- *Counting individuals for the "100-or-more" employer size*

  - Employees counted in the 100-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees, and partners who work or are expected to report for work on a particular day.
  - Those not counted in the 100-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer's group health plan.

- *Employer size increases to 100 or more during the year*

  If the employer's size meets the 100-or-more employee threshold at any time during the current year, the employer's group health plan coverage will be primary to Medicare during the following year.

  For example, an employer met the 100-or-more employee threshold on May 1, 2009. The employer's GHP coverage will be primary for services provided from January 1, 2010 through December 31, 2010.

  Please note: If you answer "No" to **Question 6**, you must promptly notify BCBSIL by completing a new EAF if your answer changes to "Yes" at the beginning of the next calendar year.

- *Employer size doesn't meet the threshold of '100 or more employees during 50 percent of business days' during the year*

  If the employer's size does not meet the 100-or-more employee threshold during the year, the employer's GHP coverage is secondary to Medicare during the following year.

  For example, during 2009 the employer's size never meets the threshold of 100 or more full-time and/or part-time employees on 50 percent or more of the employer's business days. The employer's group health plan coverage will be secondary to Medicare for services provided from January 1, 2010 through December 31, 2010.

- *Individuals affected by the disability rule.*

  The "disability rule" applies to individuals who are Medicare-entitled due a Social Security Administration determination of disability and

  - Are covered under their employer's GHP and have "current employment status" and the employer meets the "100-or-more" employer size requirements (above), or
  - Are covered under their spouse's (of any age) employer's GHP and the spouse has current employment status and the employer meets the "100-or-more" employer size requirements (above).

BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL) MEDICARE SECONDARY PAYER (MSP) EMPLOYER ACKNOWLEDGEMENT FORM (EAF)

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Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the enclosed document titled "Instructions – Completing the MSP Employer Acknowledgement Form" for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Please complete this form, sign, date and direct it to your BCBSIL Account Executive. A response is required for every question.**

Employer Name – Legal Name of Company:		Employer Identification Number (EIN):
Physical Address (number & street), City, State, ZIP:		
Account Number(s):	Group Number(s):	
⇨ New BCBSIL clients please check the correct box	☐ The client was **not** in business during the preceding calendar year	☐ The client was in business during the preceding calendar year
⇨ Current BCBSIL clients please check the correct box	☐ Submitting this EAF at renewal	☐ Submitting this EAF as an update ☐ Submitting this EAF as an error correction

Question			
Do you have any affiliates or subsidiaries? If "yes", list name of each.		☐ Yes	☐ No
Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2009, base your current year answers on 2009. Or, if your upcoming renewal is effective January 1, 2010, base your current year answers on 2010. If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes. **Please indicate the current calendar year for which the form is being completed:**		______ **Current year**	
1. In the year immediately prior to the current calendar year, did you file a separate federal tax return, that is, not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A ☐		☐ Yes	☐ No
2. How many employees did all the entities on the preceding calendar year's tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the preceding calendar year? Enter number of employees.		______ (# of employees)	
3. Are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits. Question 5 must also be completed.		☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ Check 'Yes' or 'No' for both the current and preceding calendar years	Current year (See above.)	☐ Yes	☐ No
☐ If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please check this box and enter the date the threshold was met in the following space. _______/_______/________. ☐ If you check "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF, checking this box and entering the date the threshold was met in the space above.	Preceding year	☐ Yes	☐ No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year?	Current year (See above.)	☐ Yes	☐ No
⇨ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ⇨ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Preceding year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

I understand that BCBSIL is relying on my answers to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSIL, as indicated above, if my answers to the above questions change because we have increased the number of employees.

Signature of company officer or authorized representative ____________________ Print Name ____________________

Title ____________________ Date ____________________

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INFORMATION REGARDING THE MEDICARE AS SECONDARY PAYER STATUTE

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Employers, group health plans (GHPs), and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the Medicare Secondary Payer (MSP) provisions of the Social Security Act, commonly known as the "MSP statute"[1]. The MSP provisions of the Social Security Act are similar to the coordination of benefits clauses in GHPs. As an employer[2] or administrator of a GHP, you need to know the requirements of the statute to remain in compliance and to avoid potentially costly penalties and litigation. To assist in this endeavor, Health Care Service Corporation (HCSC) provides this basic information regarding operation of the MSP statute and the enrollment and membership information system that is used to obtain necessary data to detect instances in which the MSP statute applies and to ensure the proper processing of claims consistent with the law.

THE MSP LAW

A Coordination of Benefits Approach

During the first 15 years of the Medicare program, Medicare was the primary payer of all services provided to Medicare beneficiaries, with the sole exception of services covered under a workers compensation policy or program. As a result, where a Medicare beneficiary had dual health care coverage, Medicare paid first, and the employer, GHP, or insurer paid all or a portion of the remainder of the bill for the health care item or service at issue, depending on the terms of the relevant plan or contract. In an effort to save scarce Medicare resources, Congress enacted a series of amendments to the Social Security Act, beginning in 1981, which made employers and GHPs, as well as their insurers, responsible in certain instances for making primary payment in connection with medical items or services provided to specified Medicare beneficiaries with dual health care coverage.

The MSP statute is essentially a coordination of benefits statute. It does not dictate the benefits an employer or GHP must offer, but instead simply requires instances that a GHP make primary payment where dual coverage exists for a particular health care item or service. Employers are constrained in the benefits they can offer employees and other individuals covered under the plan, however, in one important respect: the statute specifically prohibits employers and GHPs from differentiating between benefits offered to certain Medicare beneficiaries and their counterparts not enrolled in Medicare. The anti-discrimination provisions of the statute are explained more fully below.

Scope of the Statute

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and GHP coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status".

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status". If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employment status". If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees. (There is no small employer exception under the statute.)

1 The MSP provisions are set forth at 42 U.S.C. §1395y(b), as amended. The regulations the Center for Medicare and Medicaid Services (CMS) has issued regulations implementing the statute which are located at 42 C.F.R. §411.20-.37, 411.100-.130, 411.160-.175 and 411.200-.206. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations. This document is provided for information purposes and is not offered or intended as legal advice.

2 In the document, the term "employer" includes a plan sponsor or entity that contributes to a GHP.

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The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

As noted, application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on "current employment status". Thus, the MSP provisions apply to the aged only if the age 65 or over Medicare beneficiary or the beneficiary's spouse has "current employment status" and to the disabled only if the disabled Medicare beneficiary, or a member of his family, has "current employment status" with the employer. (By contrast, the MSP provisions relating to individuals who have ESRD apply regardless of whether the beneficiary has GHP coverage as a result of "current employment status" and regardless of the number of employees which an employer employs.) Under the regulations issued by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration or HCFA), an individual has "current employment status" if the individual: (1) is "actively working" as an employee, [is] the employer…or [is] associated with the employer in a business relationship;" (2) is "not actively working" but is "receiving disability benefits from an employer for up to 6 months;" or (3) is "not actively working" but "retains employment rights in the industry" and other specific requirements are met. For additional information, we again direct your attention to the statute and regulations.

The Non-Discrimination Provisions: Age and Disability

The MSP statute prohibits GHPs from "taking into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy) or which supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, "Medigap" and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status", and thus the MSP provisions do not apply.

End Stage Renal Disease (ESRD)

The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., "carve-out") and "Medigap" coverage in this context.** After the coordination period has expired, however, the GHP is free to offer "carve-out" and "Medigap" coverage to ESRD Medicare beneficiaries, but may not otherwise differentiate between the benefits provided to these individuals and all others on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner.

Special rules apply regarding retired individuals and members of their families who receive Medicare benefits on the basis of age or disability immediately before the onset of ESRD. Where immediately prior to contracting the disease, the GHP was lawfully providing only "Medigap" coverage, or was otherwise a secondary payer for that individual due to a "carve-out" provision, the GHP may continue to offer such coverage and is not required to pay primary during the 30 month coordination period. By contrast, where a GHP was providing primary benefits immediately before the onset of the disease, the GHP is responsible to continue providing primary benefits for that individual for 30 more months. This is because a change from primary to secondary or supplemental coverage would improperly "take into account" Medicare eligibility based on ESRD.

Employer Obligations

It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in "carve-out" or "Medigap" coverage under your Plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the GHP the primary payer, it is Medicare's position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract. Individuals may choose to purchase and pay for "Medigap" insurance on their own, but neither the employer nor the GHP may sponsor, contribute to, or finance such coverage.

Prohibition of Financial Or Other Incentives Not To Enroll in a GHP

An employee or spouse of an employee is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payer. It is unlawful, however, for an employer (or any one else for that matter) to offer any financial or other incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP which would be primary to Medicare if the individual enrolled in the GHP. This is so even if the incentive is offered universally to all individuals who are eligible for coverage under the GHP. Any entity violating this prohibition is subject to a civil monetary penalty under the MSP statute of up to $5,000 for each violation. **Where an employee or spouse of an employee chooses to reject the employer-sponsored health plan, the employer and GHP are prohibited from offering or sponsoring that individual's health coverage or contributing to the premium for that coverage.**

Other Consequences of Non-compliance

Non-compliance with the statute can result in serious consequences. Thus, a significant excise tax in the amount of 25 percent of the employer's or employee organization's GHP expenses for the relevant year may be assessed under the Internal Revenue Code against a private employer or employee organization contributing to a "non-conforming" group health plan. Under CMS Regulations, a non-conforming group health plan is a plan that: (1) improperly takes into account that an individual is entitled to Medicare; (2) fails to provide the same benefits under the same conditions to employees (and spouses) age 65 or over, as it provides to younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to provide required information, fails to pay correctly, or fails to refund to CMS conditional Medicare payments mistakenly made by the agency. It is Medicare's position that, in addition to the possible imposition of an excise tax, failure to reimburse CMS for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private right of individuals to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

THE INFORMATION SYSTEM

Information Gathering

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute and to assist this organization and its accounts in meeting their statutory obligations, we (HCSC) have been and continue to participate in a data exchange enrollment and membership system that was developed to electronically exchange health insurance benefit entitlement information related to the MSP statute. The system is aimed at obtaining, in a timely and current fashion, information necessary for us to identify dual coverage situations which fall within the MSP statute and to determine whether primary or secondary payment should be made for a particular claim. Section 111 of the Medicare, Medicaid and SCHIP Expansion Act of 2007 (MMSEA) (P.L. 110-173), added new mandatory reporting requirements for GHP arrangements, liability insurance (including self-insurance), no-fault insurance and workers' compensation. Responsible Reporting Entities (RREs) are now **required** by Mandate S111 from CMS to report information necessary for us to identify dual coverage situations which fall within the MSP statute. The MSP Statute requires that HCSC as Plan Administrator and/or Health Insurer act as the RRE. The sharing of data through this system helps us and our customers to meet the statutory obligations by identifying instances in which an individual participating in your GHP is or may be improperly enrolled in a program providing secondary or supplemental coverage.

CMS has, in the past, reported that it has made hundreds of millions of dollars in mistaken Medicare payments annually as a result of paying primary when under the MSP statute only secondary payment was required. Historically, many of these mistaken payments resulted from the fact that providers often filed claims which failed to identify sources of health care coverage other than Medicare and CMS lacked information in its own files regarding the existence of duplicate coverage for Medicare beneficiaries. **The information void was greatest with regard to the spouses of working-aged individuals covered by the statute and the greatest number of undetected dual coverage cases accordingly occurred in this context.**

To help remedy this problem, and as a RRE, we are continuing to provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that

CMS can supplement its files to better detect dual coverage situations. The information we require from you and provide to CMS is relatively discrete and includes the following:

Information on Employers

- Employer Identification Number (EIN)

Information on Medicare Beneficiaries

- Beneficiary Name
- Date of Birth
- Gender
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Policyholder (e.g., policyholder, spouse of policyholder, child of policyholder, other)
- Reason for Medicare Entitlement (e.g., beneficiary insured under Medicare due to age, disability, or ESRD)
- Medicare Effective Date
- Medicare Termination Date

Information on Certificate Holder/Policyholder and Covered Dependents

- Policyholder Name
- Social Security Number
- Individual Policy Number of Policyholder
- Current Employment/Retirement/COBRA/State Continuation Status
- Coverage Effective Date
- Coverage Termination Date
- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only, drug with major medical, etc.)
- Coverage (e.g., self, family, self/spouse, etc.)

Our goal is to obtain the identified information with as little inconvenience and burden to you and your employees as possible. We will gather this information through application forms and group-size questionnaires with detailed instructions on how to complete each form.

The Need for Your Active Participation

Our ability to make accurate primary/secondary determinations involving individuals enrolled in your GHP and thus to assist CMS in processing MSP claims properly in the first instance, depends entirely on the breadth and accuracy of our files concerning individuals covered by your GHP. We depend on you to provide us with this information. Accordingly, it is important that you respond promptly and accurately to our requests for information.

Moreover, to ensure the continuing accuracy of our files, it is your responsibility to notify us promptly of any changes in the size of your work force or the status of your employees that might affect the order of payment under the MSP statute, such as information regarding working-aged persons who retire (and thus for whom Medicare makes primary payment) *and changes in the size of your work force that place you in, or take you out of, the scope of the MSP statute.* **If we do not receive such information from you, we will assume that all relevant factors remain unchanged and will process claims accordingly.** We will be using the information you provide us to update our files, and will also forward this information to CMS on a quarterly basis so that CMS can revise its file to reflect relevant changes in primary/secondary status.

Amendments to the MSP Statute and Regulations

The MSP statute and regulations are frequently amended. As a result, it is important that you and your counsel continue to monitor changes in the law and assess the impact of such changes on your company. While we can assist you in meeting your statutory obligations by providing general information about the statute and gathering information that will detect potential problems in enrollment, it is ultimately your responsibility to ensure your company's compliance with the MSP statute.