Certification Required for CMS Section 111 Reporting – Minnesota

In accordance with Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, we are required to verify your employer group size annually. This mandatory verification provides us with the necessary data to report Medicare Secondary Payer information to the Centers for Medicare and Medicaid Services (CMS). This information also allows us to determine whether your group is considered a large or small group under Affordable Care Act regulations and accurately apply state and federal regulations as they relate to your group. Failure to accurately respond may result in penalties imposed by the federal government.

1) Please provide the county in which your company is primarily located within the Quartz Service Area (i.e., Filmore, Houston, Olmsted, Winona): ___________________________

2) Enter the average number of employees working at least 20 hours per week on business days during the preceding calendar year, excluding employees whose health coverage is determined by a collective bargaining agreement, and excluding individuals working on a temporary, seasonal or substitute basis.* The number of employees should not include retirees and disabled former employees required to be covered. (include all locations): _________________________________

   **Collective Bargaining Agreement: If the group insured is a collective bargaining unit, only count employees who are part of the collective bargaining unit. Do not count other employees in the company.*

3) Medicare Secondary Payer provisions apply to employers that have 20 or more full-time and / or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc.

   ☐ 2 – 19 employees ☐ 20 or more employees

4) Medicare Secondary Payer disability provisions have a different rule for reporting group size for disabled employees. When calculating your number of full-time and part-time employees you must use the total number of employees in your organizational structure including the parent company, subsidiaries, etc. Did you employ 100 or more full-time and part-time employees on 50% or more of your regular business days during the previous calendar year?

   ☐ Yes ☐ No

The Medicare Secondary Payer regulations as dictated by CMS require you to report any changes in employment during the course of the year that could impact your employer size determination related to the 20 employees or more requirements described above. In other words, you must notify us when you have had an increase to a size of 20 or more full-time and part-time employees for 20 or more weeks during the current calendar year.

5) COBRA applies to employers that employers that employ 20 or more full-time and part-time employees on 50% of the business days during the preceding calendar year. Part-time employees count as a fraction of a full-time employee and should be counted in this manner.

   ☐ 2 – 19 employees ☐ 20 or more employees

6) To determine compliance with Participation Requirements stated in your Group Master Policy Agreement provide the following:

   _______ Total Number of Employees
   _______ Number of Eligible Employees*
   _______ Number Enrolled

   *Eligible Employees do not include persons with continuation coverage as a former member of an employer group or other credible coverage unless such coverage is sponsored by the employer.

7) A minimum contribution of 50% of the single premium is required. Confirm the percentage of employer paid premium:

   _______ % Single _______ % Family

CERTIFICATION

I HEREBY CERTIFY that I have read the above statement and to the best of my knowledge and belief, it is a true, correct and complete statement prepared in accordance with the applicable instructions.
I attest that I have the authority to sign on behalf of the company represented in this survey.

Signature: ____ Date: ___/___/_____
(Officer / Owner or Group’s Contact Signature Required)

Title: ____
(Please Print)

Company Name: ____