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ALERT

Section 111 Bulletin: October 22 Section 111 Town Hall Teleconference: Confusion Continues over 1980 Cutoff Date for MSP Liability and Collection of Social Security Numbers

October 30, 2009

On October 22, 2009, the Centers for Medicare & Medicaid Services (CMS) held its most recent "town hall" teleconference regarding Non-Group Health Plan (NGHP) obligations under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). The call focused on policy questions, with much of the discussion revolving around the 1980 cutoff date for Medicare Secondary Payer (MSP) obligations and the challenges with collection of Social Security Numbers (SSN). CMS also reported that the agency plans to release a final version of the NGHP User Guide no later than the end of 2009.

Note: Because CMS has not yet made transcripts of the call available, the statements attributed to CMS personnel come from our notes, which typically summarize or paraphrase the teleconference discussion rather than record direct quotations.

Significance of the "Date of Incident" as Defined by CMS

CMS has previously stated as a matter of policy that it will not seek recovery of Medicare's conditional payments from liability insurers, self insurers and no fault insurers who pay claims with Dates of Incident prior to December 5, 1980, the effective date of the 1980 MSP statute, *unless* a claim involves exposure continuing on or after December 5, 1980. NGHPUser Guide at Section 11.10.2 (pp. 76-77). In the current issue of the NGHP User Guide, CMS defines "Date of

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Incident" as the "date of first exposure" with respect to "exposure" claims (*i.e.,* cumulative injury claims). NGHP User Guide, App. A, at 112. The User Guide provides the following example:

If "x" is sued for permitting or causing toxic exposure on a particular piece of property but sold the property prior to December 5, 1980, Medicare still has a potential recovery claim against any settlement, judgment, award, or other payment as long as the alleged injured party's exposure to the toxic property continued on or after December 5, 1980.

Id. at 77. The User Guide does not expressly identify the landowner from which it would seek recovery. The User Guide, however, also offers this example:

If an individual is pursuing a liability insurance (including self-insurance) claim against "X", "Y" and "Z" for asbestos exposure and exposure for "X" ended prior to December 5, 1980, but exposure for "Y" and "Z" did not; a settlement, judgment, award or other payment with respect to "X" would not be reported.

Id. These two User Guide examples are arguably inconsistent if the "settlement, judgment, award, or other payment" referred to in the first example is paid by or on behalf of landowner "x".

During the October 22 teleconference, CMS may have attempted to clarify the User Guide instruction and/or back away from the second example. In the teleconference, CMS stated that the User Guide's use of the word "exposure" refers to the claimant's *physical exposure*, not to the insurer's or insured's legal exposure. (Although CMS appears not to have used such a definition of exposure in the second example above.) CMS then gave the following example of its intended application of the term. Assume a landowner sold his land (containing a high level of toxic chemicals at the time of the sale) in 1978, but the tenant continued to live there until 1985 under the new landlord. If the tenant later sued both owners for his exposure to toxic chemicals, CMS advised it would consider the earlier owner's settlement (and subsequent payout) primary to Medicare because the tenant's physical exposure to the chemicals continued past 1980 - apparently even if that owner was not liable for the post-1980 exposure, the insurance policy in question provided no coverage for post-1980 exposure *and* the ownerdid not receive a release of liability for such exposure from the settling claimant. This hypothetical appears to be consistent with the first example quoted above from the User Guide, although it adds the fact that the owner did not receive a release of liability for post-1980 exposure.

Wiley Rein Comment: The CMS remarks are troubling if we heard them correctly. The statutory basis for imposing a reimbursement obligation on insurers/landowners for pre-December 1980 exposure is unclear if these entities or individuals have no contractual liability for post-1980 exposure and/or are not released from liability for post-1980 exposure (the latter being a key factor relied upon by CMS in determining Section 111 reporting obligations - *see* NGHP User Guide at Section 6 (p. 16)). Moreover, CMS's apparent belief that release language will distinguish between pre and post-December 1980 liability does not comport with the manner in which tort claims are actually settled. If not corrected or further explained, the CMS remarks are likely to lead to significant confusion and dispute.

During the October 22 teleconference, CMS, apparently recognizing industry concern with its position, invited recommendations for revised User Guide language on this exposure issue that would not only protect the industry's interests but also Medicare's right under the MSP law to recoup conditional payments. Wiley Rein has an interdisciplinary Section 111 Team in place to assist insurers or self-insured entities in drafting recommendations. To discuss the above exposure issue in greater detail or for information about the process of submitting recommendations to CMS, please contact us.

Challenges with the Collection of Social Security Numbers (SSNs) and Health Insurance Claim Numbers (HICNs)

Industry representatives have repeatedly voiced concern about the difficulty or impossibility of collecting SSNs and HICNs from Medicare beneficiaries for Section 111 reporting purposes due to privacy interests. Reporting a settlement, judgment, award or other payment to CMS is impossible without a claimant's HICN or SSN.

In the October 22 teleconference, CMS stated that the Section 111 statute does not require insurers to collect SSNs, but rather only imposes an affirmative obligation on insurers to obtain HICNs from the claimants. If insurers cannot obtain HICNs, they have the *option*, according to CMS, to use a claimant's SSN *and* other identifying information to determine if the claimant is on the Medicare beneficiary rolls.

Multiple callers in the October 22 teleconference pointed out that the difference between collecting the HICN and the SSN is illusory because the HICN is merely the SSN with an alpha suffix attached, and therefore the same privacy concerns are associated with collection of either number. CMS responded that both numbers are determined and allocated by the Social Security Administration, and CMS therefore has no control over the resolution of this issue.

Wiley Rein Comment: While CMS may not control assignment and use of SSNs and HICNs as the means by which Medicare identifies its beneficiaries, the practical reality is that privacy concerns will make collection of *either* number from Medicare beneficiaries very difficult and in many instances impossible for insurers. Liability insurers that pay third party claims and have an adversarial relationship with claimants will likely find obtaining these numbers even more challenging than group health plans or workers' compensation insurers that have contractual relationships with their claimants or their claimants' employers, respectively. We submit that CMS needs to address these issues in a less defensive and more constructive manner. In particular, CMS needs to mount an educational program encouraging beneficiaries to provide the necessary information to insurers; establish a clearly defined "safe harbor" broad enough to protect insurers when claimants fail or refuse to respond to requests for information; and consider requesting a legislative amendment to MMSEA that requires claimants to provide this information to insurers. Denying the severity of this problem or casting blame on the Social Security Administration will not facilitate the release of the required numbers to insurers or otherwise enable them to report information that they do not have and cannot acquire from claimants.

Use of CMS Model Form to Request HICNs and SSNs

In May and then in August 2009, CMS posted a form on the agency website with model language to assist insurers in collecting HICNs and SSNs when claimants are otherwise unresponsive to requests for this information. In its August 24, 2009, Alert, CMS explained that it would consider an insurer compliant with Section 111 if a beneficiary refuses to provide a HICN or SSN and that beneficiary signs a model form acknowledging his or her refusal. Although not addressed in the written Alert, CMS has, at a minimum, implied in teleconferences that proof of having *sent* a model form to a claimant who does not respond, along with other reasonable insurer efforts to obtain the HICN or SSN, *may* be enough to earn that insurer safe harbor protection.

CMS stated during the most recent teleconference that insurers may begin sending the model language at any time to uncooperative claimants and do not have to wait until reporting is required in 2010. CMS did reiterate, however, that this form should be used as a last resort, only after other attempts have been made to obtain the personal identifiers.

In response to a question about whether insurers could alter the language or format of this information request form, CMS stated that use of the form will only create an "implied safe harbor" if it is sent in its *original, unaltered form*, as provided on the CMS website. This answer is consistent with CMS's August 24, 2009, Alert.