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Section 111 Bulletin: January 28, 2010 Section 111 CMS Teleconference Summary

February 2, 2010

On January 28, 2010, the Centers for Medicare & Medicaid Services (CMS) held a "town hall" teleconference for Non-Group Health Plans (NGHPs) focusing largely on policy issues related to the implementation of the new reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Noticeably, CMS did not announce when it would release the now long-anticipated, revised NGHP User Guide, originally slated for release in the fall of 2009 but later delayed repeatedly. CMS stated that updated guidance on several topics, including "clinical trials" and "risk management writeoffs," was in the "clearance" phase and should be forthcoming in the form of individually released Alerts, but the agency did not offer any further insight into that guidance. With respect to periodic payments, CMS stated that it planned to extend its July 13, 2009 guidance for workers' compensation carriers to no-fault insurers. Some of the topics discussed in more detail included:

- **Mass Torts:** Questions still remain regarding whether and how insurers must report payments made to insureds or to settlement funds in the context of mass tort claims where there are large numbers of plaintiffs and the insurer has no involvement in or knowledge of the allocation of settlement funds to individual claimants. These situations may include, among others, an insurer's lump sum settlement with an insured to resolve large numbers of tort claims that have been handled and paid by the insured, commutation of policies or particular coverages under one or more policies, or the creation of a settlement fund to be administered by the insured or by a third party to compensate underlying tort claimants. CMS indicated, albeit with little clarity, that it was considering

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an alternate reporting process for these mass tort situations, allowing insurers to notify the agency about the establishment of a multi-claimant settlement fund, for example, through a "mailbox" system rather than the current Section 111 reporting process. This may be similar to the email inbox, also called the "Resource Mailbox" by the agency, that CMS uses to collect questions and comments about Section 111. In short, this option would likely be an informal notification system, allowing insurers to fulfill their notification obligations without identifying payments to individual claimants and allowing CMS to pursue reimbursement for conditional payments from large settlement funds.

- **"Foreign" Insurers:** The agency stated that it is close to releasing an Alert regarding the Responsible Reporting Entity (RRE) obligations of non-U.S. liability or no-fault insurers that "do business" in the United States. This guidance is expected to include a definition of "doing business" for purposes of identifying RREs with Section 111 obligations. We might expect overseas insurers writing policies in the United States on an admitted basis to satisfy such a definition, but question whether overseas insurers issuing policies overseas to manufacturers that export goods into the United States or sell products to Medicare beneficiaries overseas could qualify as "doing business" within the United States sufficient to avoid the constitutional presumption against the extraterritorial application of domestic law. CMS indicated that at some later date, the agency will release additional guidance for non-U.S. *self-insured* entities, such as overseas manufacturing companies, that CMS *may* conclude are beyond the reach of Section 111 if they export products into the United States but do not otherwise "do business" within U.S. borders. In light of this anticipated guidance, we recommend that all overseas insurers and self-insured entities closely examine their legal obligations under U.S. law before registering with CMS under Section 111. Last month, CMS stated that it would release registration instructions for overseas RREs by April 1, 2010, so that non-U.S. insurers that must report under Section 111 would be able to begin the registration process by that time.

- **December 5, 1980 MSP Effective Date for Liability Insurers:** Although CMS stated that it was still reviewing industry comments, the agency did note that it was giving particular consideration to the scenario where all "exposure clearly ended" by December 5, 1980, but the insurer received a release beyond that time period. CMS did not define "exposure."

- **RRE Clarifications:** It has been a long wait for a revised Section 7.1 of the User Guide ("Who Must Report"), for which CMS solicited comments on July 31, 2009. CMS representatives stated that they are still "working on" this Section, but they did offer some guidance in response to caller questions. For example, one caller identified the situation where an insurer writes a liability policy with a deductible, thus qualifying the insured as a self-insured entity under the User Guide. The insurer has a contract with an unaffiliated third-party administrator (TPA) to administer claims. When the insured funds a claims settlement, it sends the money to the TPA, and the TPA then pays the claimant. The insured has no

contractual relationship with the TPA. Under this scenario, in which we understood the insurer not to pay any portion of the settlement, CMS stated that it might nevertheless designate the insurer as the RRE, not the partially self-insured entity. CMS confirmed that it will address this question specifically, as well as others, in upcoming guidance.

- **Medicare Set-Asides:** CMS reiterated on this call that it stands by its many prior pronouncements that Medicare Set-Asides (MSAs) are *not* required under the law for NGHP settlements, but clarified that this pronouncement did not mean it would be *inappropriate* to set up an MSA for an NGHP settlement, especially because insurers "must protect Medicare's interests" - a frequent CMS refrain that is never defined by legal citation. We agree that a liability insurer must reimburse Medicare for "conditional payments" when required to do so under 42 U.S.C. § 1395y(b)(2)(B), comply with Section 111 reporting requirements under that same statute, and give CMS notice under 42 C.F.R. § 411.25 when the insurer knows that Medicare has paid for medical expenses it has paid or will pay a Medicare beneficiary, but urge CMS to clarify if it sees broader duties of "protection" falling on liability insurers.

  MSAs have been common in the workers' compensation industry for many years. MSAs typically require pre-settlement discussions between workers' compensation plans or carriers and a CMS Regional Office regarding the amount of money that should be set aside to pay for a beneficiary's future injury-related medical expenses. An MSA theoretically protects Medicare's interests by ensuring that a portion of the settlement proceeds are set aside to cover such expenses and that Medicare does not pay until those private funds are exhausted. On the call, CMS suggested that Regional Offices may be able to look as well at MSAs proposed by liability insurers if the Regional Office's workload permits. Although not traditionally used in many sectors of the liability insurance industry, some insurers, particularly no-fault insurers, may decide to utilize MSAs for business reasons when accepting responsibility in an NGHP settlement for the ongoing payment of medical expenses (referred to as ORM). It is important to remember, however, that MSAs do not shield insurers from CMS's recovery of conditional payments (that is, Medicare's payment of *pre-settlement* medical expenses), unless funds are set aside for that purpose as well. That protection can be achieved through use of an escrow agreement or other mechanism providing for the satisfaction of any reimbursement obligation to Medicare from settlement proceeds.

- **No-Fault Insurance:** CMS stated that it continues to classify "Occupational Health and Accident," "Accident and Health," and "Accident" policies as no-fault policies despite continued disagreement from some insurers. CMS invited insurers to send in the policies they contend fall outside a no-fault classification to the Section 111 Resource Mailbox at PL110-173SEC111-comments@cms.hhs.gov.

- **Small Businesses:** CMS reiterated that in the NGHP realm there is no Section 111 reporting exemption for small employers or businesses, noting that there has been some confusion with the Small Employer Exception that exists under Medicare Secondary Payer law for entities providing health care benefits to fewer than twenty employees. According to the current User Guide, all self-insured NGHP entities, regardless of size, must report under Section 111 if they intend to make a payment for bodily injury to a Medicare beneficiary, unless an insurer also carries reporting obligations and will be making payment to the claimant itself.

The next NGHP town hall teleconference, scheduled for February 10, 2010, will focus on technical aspects of the Section 111 registration, testing, and reporting processes and common challenges and frustrations experienced by registering and testing RREs.

Our Section 111 Team routinely covers the Section 111 teleconferences typically held twice a month by CMS, and we send timely detailed summaries of teleconference highlights to our clients. We also maintain a searchable electronic database of teleconference transcripts back to October 2008. Please let us know if you would like more information about any of the topics discussed during the January 28, 2010 call. You may also access our Section 111 webpage and the Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.