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ALERT

Section 111 Bulletin: CMS Significantly Revises Mandatory Insurer Reporting Guidance for NGHP Responsible Reporting Entities

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In a Section 111 "town hall" teleconference for Non-Group Health Plans (NGHPs) held on February 25, 2010, the Centers for Medicare & Medicaid Services (CMS) announced major revisions to previously issued guidance for Responsible Reporting Entities (RREs), no doubt welcomed by many self-insured entities but which will impose greater burdens on insurers due to issues of substantial impracticality. Under the new guidance, entities that are self-insured only in the sense that they pay a deductible will no longer be required to report under Section 111, unless they do not notify their insurers of payments they make directly to claimants. CMS also announced that, in line with the postponement of the mandatory reporting start date until the first quarter of 2011, CMS will push back the dates of claims settlements, judgments, awards and other payments that insurers and self-insured entities must report in their initial reporting cycle in 2011.

During the teleconference, CMS announced the pending release of three Section 111 Alerts for NGHPs, only two of which are currently available on the CMS Section 111 website, and Version 3.0 of the NGHP User Guide, posted today. The two posted Alerts address 1) what constitutes "compliance" with Section 111's reporting requirements, and 2) who must report under and thus comply with Section 111 (updating the July 31, 2009 NGHP Alert on the same subject and Section 7.1 of the User Guide). CMS stated that the third Alert provides information about various issues that have been of concern to RREs, including foreign insurer registration, data fields Nos. 58-62 on the Claim Input File Record, clinical trials, and risk management activity. Although apparently none of the three Alerts

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has been incorporated into Version 3.0 of the User Guide, CMS stated during the teleconference that the Alerts contain "final agency guidance."

Yesterday's teleconference and the two posted Alerts provide the following guidance on Section 111 implementation for insurers and self-insureds:

- **Revised Reporting Timeline:** When NGHP reporting commences in the first quarter of 2011, insurers and self-insured entities will only be required to report Total Payment Obligation to the Claimant (TPOC) amounts that are settled or adjudicated (but not necessarily paid) on or after October 1, 2010 (previously January 1, 2010), and claims involving Ongoing Responsibility for Medicals (ORM) that are settled or adjudicated on or after January 1, 2010 (previously July 1, 2009). Responsible Reporting Entities (RREs) that are ready to begin reporting certain lines of business or certain sets of claims can commence reporting for those specific claims prior to January 1, 2011, even if they do not report all resolved claims, if they have completed testing and moved to production status.
- **RRE Designation:** CMS has revised its guidance regarding what entity must report in situations involving deductibles. According to the new guidance, an entity that is self-insured to the extent that it pays a deductible will seldom be responsible for reporting a claims payment to CMS if the entity files the third party claim with its insurer. According to CMS, the insurer will be responsible for reporting any and all payments made by both the insured and/or the insurer (above and below the deductible) to CMS. Even if the amount paid to the claimant does not exceed the deductible, and the insured pays the entire amount itself, the insurer is the RRE for that claim. As now written, this guidance apparently means that insurers will need to ensure they receive timely information about *all* claims paid out by their insureds, even when the amount paid is below the deductible. Entities with self-insured retentions and excess coverage will still follow the original guidance, which determines the RRE based on which entity (insurer or insured) physically pays the claimant. In addition, CMS has now defined "deductible" as the risk the insured retains with respect to the coverage provided by the insurer, and defined "self-insured retention" as the risk the insured retains that is not included in the coverage provided by the insurer. Payment is now defined as the *physical* act of paying a claimant, not the ultimate assumption of financial payment or reimbursement of a claims payment. Finally, with respect to fronting, CMS states that "the intent with *fronting* policies is that the insurer will never pay a claim", and thus where the insured does pay the claim, the insured is the RRE."
- **Entities With a Low Volume of Claims:** CMS is working on an alternative reporting process for entities that have a very low volume of reportable NGHP claims payments. The Agency, noting that it is in the beginning stages of developing this process, and cautioning that nothing is guaranteed, promised to provide more information in the near future.
- **Compliance With Section 111:** This Alert summarizes the steps, already outlined in other guidance, that insurers and self-insured entities must take to become "compliant" with Section 111, namely: 1) *registration* with the Coordination of Benefits Contractor (COBC); 2) data exchange *testing* with the COBC; and 3) regular *production* data exchange with the COBC (beginning in the first quarter of 2011). The Alert does indicate that if an RRE is unable to register during the designated timeframe (suggested

by CMS to be prior to September 30, 2010), it should notify the COBC of its inability to register and obtain approval from the COBC for a later registration date. Moreover, CMS defines compliance with Section 111 as producing (subsequent to the initial reporting cycle) Claim Input Files that are of a quality that enables the COBC to successfully process the submitted data. The implicit message during the call was that CMS does not intend, at least at this time, to assess penalties against an RRE that remains in such compliance or data dialogue with CMS, but makes errors in the reporting process or may have a reasonable, good-faith misunderstanding of CMS's guidance.

Based on CMS statements during yesterday's teleconference, the revised User Guide does not resolve several other important issues that have been the subject of industry questions and debate, including:

- Reporting of mass tort claims payments
- Application of the December 5, 1980 MSP effective date and related "exposure" issues
- Severance packages and employment liability settlements with global releases where the policies were never intended to cover medical expenses and/or medicals were never claimed

Much of the information contained in this Bulletin is derived from CMS's oral presentation during yesterday's teleconference. After taking a closer look at the Alerts and revised User Guide, we will post another Bulletin addressing the new guidance.

Our Section 111 Team routinely monitors agency action regarding MMSEA mandatory insurer reporting and Medicare Secondary Payer requirements. You may access our Section 111 webpage and the other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.