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ALERT

Section 111 Bulletin: CMS Releases Long-Awaited Guidance for Foreign Insurers; Reporting Exception for Professional Liability Lines Remains Under Consideration

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On February 23rd, the Centers for Medicare & Medicaid Services (CMS) held a Town Hall teleconference focusing on policy questions from non-group health plan insurers (NGHPs) that must report claims payments under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. CMS announced it had posted four Alerts to the Section 111 CMS website since the last Section 111 teleconference on February 9. Although the Agency did not discuss the Alerts in any detail, we report on their implications below. Highlights from both the teleconference and the Alerts include:

Reporting Exception for Professional Liability Lines: Perhaps the most welcomed news for many Responsible Reporting Entities (RREs) was CMS's announcement that it is still considering a Section 111 reporting exception for Professional Liability (PL) lines. CMS clarified that any exception, if approved, would apply only to insurer payments to Medicare claimants who have not made "allegations of bodily injury or emotional distress" and do not expressly release claims with such allegations. CMS is considering this exclusion to address the common industry practice of including general releases, such as "for any and all claims", in settlement documents. Under CMS's current interpretation of an insurer's Section 111 reporting obligations, such a general release, standing alone, would trigger mandatory reporting. PL carriers have lobbied hard for a reexamination of the Agency's position, pointing to the unreasonableness of requiring significant carrier investment in the implementation and maintenance of a compliant Section 111 program that is unlikely to lead to Medicare

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recoupment of conditional payments. While the PL carrier burden would be lessened under the proposed reporting exception, some burden would remain as PL carriers would still need to monitor all claims for allegations or express releases of bodily injury and emotional distress, despite the very low likelihood that some PL lines would ever pay for or expressly release medical expenses. CMS should consider excepting certain lines from reporting altogether. To the extent such a line might occasionally pay a Medicare beneficiary for bodily injury, existing law would require the carrier to pay primary to Medicare and to notify CMS of the carrier payment and any conditional payments of which the carrier was aware.

The language used in any exception promulgated by CMS will be critical to the implications the exception will have for PL carriers. For instance, a more specific requirement that Medicare claimants not have made "claims of" bodily injury or emotional distress, coupled with a written claims requirement (in the form of a letter or complaint), might present less ambiguity than the use of the term "allegations" in the proposed exception.

CMS offered no date by which it will announce a decision.

Foreign Insurer Alert: In a document dated February 7 but not published on the CMS Section 111 website until February 23, CMS released the long-awaited Alert for Foreign Insurers. This guidance attempts to clarify which non-U.S. liability, no-fault, and workers' compensation insurers fall within the regulatory reaches of Section 111. This guidance does not apply to liability or workers' compensation *self-insurance*. Not surprisingly, the guidance is overly broad, potentially pulling larger numbers of non-U.S. insurers into Section 111 reporting than the U.S. Constitution permits.

The Alert instructs a foreign insurer RRE to report under Section 111 if it is "doing business within the United States" or if a court of competent jurisdiction has exercised jurisdiction over the insurer with respect to a particular claim. Entities "doing business" in the United States has been defined expansively by CMS to include:

- Entities registered in one or more of the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, or the Virgin Islands
- Entities not registered in a U.S. state, district, or territory but that have a "definite presence" in the United States, including entities:
  - Issuing or delivering insurance contracts to persons or corporations licensed to do business in the United States
  - "Soliciting applications for insurance contracts registered in [the United States]"
  - Collecting premiums and other fees for insurance contracts in the United States
  - Transacting other insurance business functions in the United States

It appears that if insurers engage in any of the above activities, CMS not only expects them to monitor and report claims payments on their U.S. lines of business, but also conceivably to monitor and report claims payments on insurance contracts that were issued and paid for abroad. Under the guidance as currently written, an overseas insurer who does *any* business in the United States will have to report *all* claims payments to Medicare beneficiaries, regardless of whether the insurance contract giving rise to such a payment was issued abroad to an overseas company that put a product into the international stream of commerce that ultimately caused the beneficiary's injuries. Although there may not be a large number of Medicare beneficiaries making claims on such contracts, the real issue for many overseas insurers will be the time and cost associated with monitoring claims and the potential for significant penalties for failing to report a claim, despite the limited likelihood of incurring a reporting obligation.

CMS's guidance goes beyond any reasonable extension of regulatory authority over claims paid on insurance contracts issued by non-U.S. insurers either to U.S. entities or to non-U.S. entities through U.S. channels of commerce. Moreover, CMS's apparent belief that a court's exercise of jurisdiction over a non-U.S. entity, typically based on the minimum contacts test, alone gives U.S. agencies the power to impose comprehensive regulatory schemes on that non-U.S. entity is ill-founded. There is a longstanding presumption under federal case law that federal statutes apply only to actions within the United States. This canon of statutory construction only permits a broader reach outside the United States if: (i) Congress has clearly manifested an intention to reach extraterritorial activities; (ii) the conduct to be regulated occurs, nevertheless, inside the United States; or (iii) not applying the statute extraterritorially would result in adverse effects within the United States. *See, e.g., Environmental Defense Fund, Inc. v. Massey,* 986 F.2d 528, 531 (D.C. Cir. 1993). Section 111 and its mandate to CMS do not manifest any intent to regulate extraterritorially. Furthermore, the conduct regulated by Section 111 (the insurer's payment to the claimant to compensate for medical services) often occurs outside the United States for overseas insurers. Finally, any argument yet to be articulated by CMS that failure to apply the statute extraterritorially would have sufficient adverse effects in the United States to justify burdening overseas insurers would not be persuasive.

Mass Torts Conference Call: CMS announced that it will hold another dial-in conference call in March (date to be announced) with those individuals who have participated in past sessions of what CMS and the industry previously referred to as the Mass Torts working group. CMS clarified that the working group's name is a misnomer as the group's focus is broader than mass torts, centered on one or more claims arising out of ingestion, implantation or exposure to toxic substances on or after December 5, 1980. Prior to the call CMS plans to distribute a new draft of its September 29, 2010 definition of those claims falling under the pre-December 5, 1980 exception to MSP liability.

"Beneficiary Lookup" Tool Available March 1: In its Alert: Beneficiary Lookup Online Query Capability for RREs posted February 23 but dated February 11, CMS announced that a new online, real-time query capability to determine whether a claimant can be matched to a Medicare beneficiary will be available starting March 1. NGHP RREs that have not selected the Direct Data Entry reporting option and are in a production status will be able to submit up to 100 query requests per calendar month using the new Beneficiary Lookup on the Section 111 Coordination of Benefits Secure Website (COBSW). The system will

display a continuous count of an RRE's remaining queries until it resets to 100 on the first day of each succeeding calendar month. Each query will count against the 100-query limit regardless of whether a beneficiary match is found. The Beneficiary Lookup will not be available to RREs that have selected the DDE submission method.

The Beneficiary Lookup will use the same criteria and methodology as the Query Input File and Claim Input File. Use of the Beneficiary Lookup is optional-no special application or sign-up is required. RREs using the Beneficiary Lookup also are free to continue submitting a monthly Query Input File as documented in the User Guide. Either query tool requires the RRE to submit:

- a HICN or SSN (if both are submitted, only the HICN will be used for matching),
- the first initial of the injured party's first name,
- the first six letters of the injured party's last name,
- the injured party's date of birth, and
- the injured party's gender.

After matching either the HICN or SSN, at least three out of the remaining four criteria must match exactly to determine a match. If the query is matched to a Medicare beneficiary, a message will provide the following information:

- current HICN Medicare has on file for the beneficiary,
- SSN supplied by user, if applicable,
- current first name Medicare has on file for the beneficiary,
- current last name Medicare has on file for the beneficiary,
- current date of birth Medicare has on file for the beneficiary, and
- current gender Medicare has on file for the beneficiary.

If the query does not return a match, a message will indicate that no match has been found but will not provide any information concerning the reason why.

Direct Data Entry (DDE) Guidance: In a series of three Alerts, each dated February 14, 2011, CMS made announcements related to the DDE option for RREs and reiterated old advice. CMS reminded listeners that the DDE option is only available to "Small Reporters", defined as RREs that will submit 500 or fewer NGHP claim reports per calendar year. Submissions that do not result in a match to a beneficiary count toward the 500 claim report limit. An RRE that has already registered for Claim Input File reporting through downloadable CMS software but now wishes to switch to DDE reporting, may do so through the COBSW website.

An RRE using DDE must report each claim within 45 days of assuming or terminating ORM or paying TPOC amounts.

The implementation date for the DDE reporting option is now July 11, 2011 (rather than March 1, 2011). Claims not reported until July 11 will not be considered late, but RREs must still report ORM obligations assumed after January 1, 2010, and TPOC amounts paid after October 1, 2010. The deadline to complete retroactive reporting is September 30, 2011.

Deductibles vs. Self-Insured Retentions: CMS again emphasized that the Agency's definitions of deductibles and self-insured retentions (SIRs) may differ somewhat from the industry's use of those terms. The Section 111 NGHP User Guide defines "deductible" as the risk the insured retains with respect to the coverage provided by the insurer, and "SIR" as the risk the insured retains that is not included in the coverage provided by the insurer. During last Wednesday's teleconference, CMS clarified that insurance sits "on top" of an SIR, whereas a deductible is included in the overall insurance policy limits. For example, CMS explained that under its approach if an insured has a $500,000 SIR and a $1 million dollar policy, after the insured pays out $500,000, there is still $1 million of coverage available. Conversely, if the same insured has a $500,000 deductible, they would only really carry $500,000 worth of insurance because once the insured paysout the first $500,000, the insurer would only be liable for another $500,000.

Increased Focus on Recovery Actions: In the past, CMS has appeared to shy away from discussing Medicare Secondary Payer Recovery Contractor (MSPRC) recovery actions in too much detail, preferring to focus on the reporting aspect of Section 111 rather than its more ominous implications for reimbursement down the road. On Wednesday's call, however, CMS spoke about MSPRC recovery actions quite candidly. CMS discussed the fact that although some states' wrongful death statutes exclude compensation for medical expenses, RREs are still required to report payments made under those statutes. But CMS followed up that the RREs might use those statutory exclusions as defenses to any later MSPRC recovery demand. On a separate topic, CMS reiterated that it is not required to abide by the settlement allocations of the parties, but stated that such allocations could be used as defenses to reimbursement actions in the future. This openness about the inevitability of MSPRC recovery actions lends gravity to the reporting obligations that have already begun and will be in full swing by this time next year. CMS reminded listeners that it will make a demand for reimbursement on the beneficiary before looking to other liable parties under the MSP statue, such as insurers.

New ICD-9 Diagnosis Code Listing: CMS confirmed its announcement earlier this month that it will post a partial list of ICD-9 diagnostic codes to the Section 111 website that will identify the Agency's selection of most likely to be reported diagnosis codes. As a reminder, a November Alert posted to the Section 111 website announced that insurers will be permitted to use the "NOINJ" (no injury) ICD-9 code for settlements that release medical expenses or claims for bodily injury or emotional distress despite the fact that no bodily injury or emotional distress has been claimed or alleged.

Self-Insurance Pool and Joint Powers Authority: The NGHP User Guide states that "[e]ntities self-insured in whole or in part with respect to liability insurance or workers' compensation may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool such as a joint powers authority" (see pg. 25 of NGHP User Guide v. 3.1). The RRE is the self-insurance pool if the pool meets all three stated

characteristics in the User Guide; otherwise, the pool may register as the agent of the RREs that are the members of the pool. CMS stated on the call that it will make no exceptions.

The next NGHP town hall teleconference call will be held on March 9 and will focus on technical questions. You can find the agenda and dates for the upcoming Section 111 teleconferences here.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held monthly by CMS, and we send periodic Alerts to our clients addressing notable town hall discussions and other Section 111 developments. We also maintain a searchable electronic database of town hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Alert. You also may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.