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ALERT

Section 111 Bulletin: GAO and Federal Court Weigh in on Section 111 Infirmities But It's Business as Usual for CMS During Town Hall Call

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The most newsworthy Section 111 developments come from a federal District Court that recently declared a legal malpractice insurer not to be a Responsible Reporting Entity (RRE) and the U.S. Government Accountability Office (GAO) with its release of recommendations for the Section 111 program after a year-long critical study.

Federal Court Rules Congress Did Not Intend Professional Liability Funds To Be Primary Payers Under Medicare

The United States District Court for the District of Oregon ruled on March 29th, in a case of first impression, that the Oregon State Bar Professional Liability Fund (PLF), although clearly a liability insurer, was neither a "primary plan" under the Medicare Secondary Payer (MSP) statute nor an "applicable plan" under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). *Oregon State Bar Professional Liability Fund v. U.S. Dep't of Health and Human Svcs.,* 2012 U.S. Dist. LEXIS 43790 (Mar. 29, 2012). Accordingly, the PLF was not subject to Section 111 reporting requirements.

Although the court did not avail itself of legislative history, the court reasoned that the PLF did not offer the type of liability insurance "that Congress contemplated when it imposed reporting requirements for primary plans that have a repayment obligation to Medicare," choosing to rely upon what the court deemed to be the plain meaning of the MSP statute. In particular, the court found it

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

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dispositive that:

the PLF does not cover claims of tortious conduct that results in bodily or emotional injuries. A malpractice claim comes to the PLF years after an attorney has erred in the provision of legal services. If the PLF pays a claimant, it is paying for a claim arising from legal malpractice, not health care services. Under these circumstances, the PLF will never have primary responsibility for paying items or services claimed by a Medicare beneficiary, and thus will never be subject to repayment obligations to [Medicare].

The court's decision is likely to be the subject of an appeal unless, perhaps, Centers for Medicare & Medicaid Services (CMS) excepts out certain specialty lines or specialty line settlements from Section 111 reporting. While the court's decision was welcomed by many in the industry and may offer a logical construction of the MSP statute, many public commentators have opined that the court's reasoning is unlikely to withstand appellate scrutiny. Those commentators have argued, for example:

(1) The court overlooks the fact that an act of malpractice itself could give rise to a claim for emotional harm suffered by the lawyer's client.

(2) The client, as a result of the lawyer's malpractice (perhaps leading to a default judgment), may have paid for health care services received by a third party as the result of bodily injury or emotional distress attributed to the actions of the client. In that scenario, if the PLF reimbursed the client for such payment, it arguably is responsible for making payment, albeit indirectly, for health care items or services paid by Medicare. The MSP statute defines a primary plan as an entity "with responsibility" for making payment "directly . . . or otherwise . . . with respect to" the same health care items or services paid by Medicare.

(3) The fact that the PLF's payment may come years after the date of the health care services is not atypical for liability insurance. Under this reasoning, few liability insurers would ever be primary plans.

(4) The court appears to presume that the Medicare statute would find only one payer to be primary in any situation. That is not true. There can be multiple commercial primary payers, whose order of payment is determined through rules governing coordination of benefits and subrogation.

(5) Because the MSP statute is ambiguous, legislative history should be consulted.

There are, of course, counterarguments and responses to these views, which are likely to be sorted out on appeal in this case or by other courts. The court's decision, however, represents an important step in defining the contours of Section 111 reporting requirements in the context of Professional Liability coverages. It is critically important to insurers that they have a clear judicial resolution of the question of whether the statute was intended to, or should, require that certain lines of insurance engage in the burdensome Section 111 reporting process in order to facilitate very limited recoveries by the federal government. As even CMS appears to recognize, its current guidance that a liability insurer must report the settlement of any claim that alleges bodily injury or emotional distress and/or receives a general release in settlement (regardless of coverage or evidence supporting such allegations) is overbroad and may be vulnerable to attack.

GAO Report Criticizes CMS's Implementation of NGHP Mandatory Reporting

In early April, the GAO released a March 9, 2012 report entitled Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans. The report, which summarizes a GAO audit of the Section 111 program, was conducted from February 2011 through March 2012, and reflects input from CMS, its contractors, insurers and Medicare beneficiaries. While the report portrays the implementation of mandatory insurer reporting by Non-Group Health Plans (NGHPs) under Section 111 as a positive event, it also criticizes many aspects of CMS's implementation of the Section 111 program.

GAO's positive finding is attributable to GAO's calculation that Medicare is now saving an additional $100 million dollars a year after paying its Medicare contractors an extra $21 million a year to collect that savings. Not surprisingly, most of the savings is tied to claims denials and conditional payment recoveries attributed to liability insurance. GAO did not attempt to quantify the added costs of regulatory compliance on NGHP insurers.

The report criticizes several aspects of CMS's implementation of mandatory reporting, including a decline in productivity of the Medicare Secondary Payer Recovery Contractor (MSPRC), which now averages 76 days to issue a demand letter if it first learns of an MSP situation after settlement, and 48 days if it receives prior notice of the situation.

The report highlights the continued difficulty of NGHPs in: i) securing information from claimants needed to determine Medicare status; ii) identifying ICD-9 codes that match insurer payments; and iii) obtaining CMS guidance from the poorly designed and maintained Section 111 website that relies upon numerous "alerts" to promulgate changes to policies and procedures. Finally, the report underscores the counter-productivity of reporting small settlements, suggesting that a monetary threshold (such as settlements larger than $25,000) would ease reporting burdens on NGHPs without forgoing significant recoveries. CMS reportedly is considering the use of permanent reporting thresholds, though it has indicated it needs more data before reaching any decisions.

GAO offered five recommendations to CMS: 1) periodically review reporting thresholds, 2) consider making the reporting of ICD-9 codes optional, 3) improve the Section 111 website, 4) provide more guidance on the use of Medicare set-aside arrangements, and 5) improve correspondence with Medicare beneficiaries. CMS's comments largely concurred with each of the recommendations except the second recommendation regarding ICD-9 codes.

Town Hall Announcements

Although CMS may be working toward implementation of these GAO recommendations, CMS is not yet talking. Here is a high-level summary of the discussion during the April 24th Section 111 Town Hall Teleconference for NGHPs:

Multiple Claim Submissions per Quarter: CMS began the call with the welcomed announcement that RREs may now submit multiple Claim Input Files per quarter. CMS cautioned, however, that RREs may not submit a second file until after receipt of the Claim Response File for the first file submission. CMS further advised that RREs should not submit more than one file within a 14 day-period. Although RREs are not required to send more than one file per quarter, CMS believes more frequent reporting will assist RREs in timely reporting Ongoing Responsibility for Medicals (ORM) terminations, as well as settlements generally. CMS stated it intends to issue an Alert with more details in the near future.

Revised User Guide Expected in May: CMS also announced that it anticipates issuing a revised NGHP User Guide in May, before Memorial Day. Little more was said about its contents, other than to promise a new example designed to better explain reporting among multiple defendants with joint and several liability.

Once an SIR, Always an RRE: CMS affirmed past guidance when it advised one caller that an insurer may not agree to pay and then report a settlement for a self-insured retention (SIR) policyholder, with the promise of later reimbursement by that policyholder. The policyholder must remain the RRE.

Generous Fully-Insured Policyholder Becomes RRE: A fully-insured policyholder (other than an individual) that wishes to contribute to a settlement over and above the policy limits becomes an RRE with respect to the amount it contributes and thus must report that contribution if it is over the applicable Total Payment Obligation to Claimant (TPOC) threshold. The fact that the RRE may pay the full settlement amount to the claimant, or that the settlement agreement only references the full amount, is irrelevant.

Multiple Defendants, One Settlement Amount: Despite the parties' inclusion in a release of only the total settlement amount contributed to by multiple defendants/insureds, each RRE has an obligation to learn and report its allocable share of the settlement amount, absent joint and several liability.

TPOC Date/Delayed Funding: If the identity of a claimant who will receive settlement monies from a global settlement fund, and/or the amount to be paid to that claimant, is not known at the time of execution of the global settlement, the TPOC date for that claimant will be the date the defendants' obligation to that individual claimant is defined by a specific monetary amount. This is not an example of delayed funding. The

TPOC date is not the date of the global settlement.

Reporting Annuities: Where a settlement requires the purchase of an annuity by multiple defendants, the reported TPOC settlement amount must include the value of the annuity payments. Each RRE must calculate and report its allocable share of this amount (assuming no joint and several liability) to CMS.

Still Awaiting a Specialty Line Reporting Exception: Listeners were disappointed if they had hoped to hear CMS announce a Section 111 reporting exception for certain specialty lines (like D&O/E&O and employment liability)—in which bodily injury and emotional distress damages are rarely alleged but use of a general release currently requires reporting.

The next Town Hall Teleconference will be held on Thursday, May 24, 2012, and will address both technical and policy issues.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held most months 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.*