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ALERT

Section 111 Bulletin: A Closer Look at Medicare's Significant Revisions to Mandatory Insurer Reporting Guidance for Property and Casualty Insurers

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On February 26, 2010, the Centers for Medicare & Medicaid Services (CMS) released Version 3.0 of the Medicare, Medicaid, and SCHIP Extention Act of 2007 (MMSEA) Section 111 User Guide for Non-Group Health Plans (NGHPs). Publication of the revised User Guide, originally slated for release in September 2009, was postponed repeatedly as CMS attempted to address numerous problems and uncertainties regarding the application of the reporting scheme, originally designed for group health plans, to the claims handling practices of liability, no-fault, and workers' compensation insurers and self-insured entities. As expected, the updated User Guide has answered some of the serious compliance questions posed by insurers and self-insured entities over the past year. Indeed, there appear to be welcomed fixes for some of the frustrating technical problems with the data exchange process, as well as practical revisions to the electronic Claim Input File Layout. Many of the more fundamental questions raised by insurers, however, were left unanswered, thus arguably creating greater operational challenges for insurers than before.

In a Section 111 Alert also posted to the CMS website on February 26 and titled "Information about required reporting", CMS acknowledged that it has yet to address several critical reporting issues raised by the industry. CMS explained that it intends to post additional

Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

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guidance for "risk management activity and clinical trials where the sponsor has agreed to pay for items or services related to injuries or complications." CMS also promised to release guidance in two additional areas:

- foreign insurer reporting (which, we assume, will tackle London market/subscription issues and hopefully carve out overseas insurers and policies that CMS has no regulatory power to reach under the Constitution), and
- reporting requirements for Fields 58 - 62 on the Claim Input File Detail Record.

During the February 25 NGHP Town Hall Teleconference, CMS announced that it also continues to assess issues raised by insurers concerning the reporting of mass torts/products liability claims payments for which insurers typically do not have claimant information in their possession. CMS offered no timetable for its issuance of this long anticipated guidance.

This Alert and the updated NHGP User Guide were preceded by two CMS Alerts posted to the CMS website on February 25. They provided guidance concerning:

- what constitutes "compliance" with Section 111's reporting requirements, and
- who must report under Section 111 (updating the July 31, 2009 NGHP Alert on the same subject and Section 7.1 of the User Guide, Version 3.0).

The Wiley Rein Section 111 Team released a Bulletin on Friday, February 26, summarizing these two Alerts and the February 25 teleconference, during which CMS discussed some of the major changes in the new Section 111 guidance. It should be noted that during the teleconference, CMS acknowledged an error it had made in the "Who Must Report" Alert, explaining that Appendix G of the User Guide, which is attached to that Alert, still contains portions of the prior "Liability Self-Insurance" reporting definition, now superseded by the new guidance identifying who must report when a deductible is involved.

The most substantial changes to CMS's Section 111 guidance are:

- **Delayed Start Date for Initial Reporting:** CMS has pushed back the initial date for NGHP reporting under Section 111 from the second quarter of 2010 to the first quarter of 2011. RREs are, nevertheless, allowed to begin reporting prior to 2011 once they have completed testing and achieved "production status", even if they are not yet able, or do not wish, to report all claims payments.
- **Revised Dates that Trigger Reporting Obligations:** When NGHP reporting commences in the first quarter of 2011, Responsible Reporting Entities (RREs) will report TPOC amounts (*i.e.,* an insurer's Total Payment Obligation to the Claimant) that are settled or adjudicated (but not necessarily paid) *on or after October 1, 2010*(previously triggered on January 1, 2010), and claims for which the insurer has or had an ongoing responsibility to pay future medical expenses as incurred by the Medicare beneficiary (*i.e.,*ORM amounts) *as of or after January 1, 2010* (previously triggered on July 1, 2009), regardless of the initial date responsibility for future medical payments was assumed. If a TPOC settlement requires court approval, the date such approval is obtained is the relevant trigger date for reporting.

- **Oversimplification of the RRE Designation:** CMS's attempt to craft a bright-line rule for designating RREs between insureds and insurers has only added to the list of impracticalities and unworkable situations arising out of the agency's Section 111 guidance. Under the new guidance, an entity that is self-insured to the extent that it accepts a deductible (not to be confused with a self-insured retention or SIR) is not the RRE, unless it acts without recourse to its insurer. In other words, this insured will not be responsible for reporting any claims payments under Section 111 *if* the insured gives notice of the claim to 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. Thus, 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 third party claim. Accordingly, insurers will need to ensure they receive timely information about all claims paid by their insureds, even when the amount paid is below the deductible. By contrast, entities with self-insured retentions and excess coverage will continue to follow CMS's 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 defined as the *physical act* of paying a claimant, not the ultimate assumption of financial payment or reimbursement of a claims payment.

  Wiley Rein Comment: The revised CMS treatment of payments made by insureds under policies with deductibles appears to be impractical and unworkable in many situations in which the insurer is unlikely to receive timely and accurate information from its insureds, including:

  - cases in which the insurer disputes or denies coverage for the claim,
  - claims as to which the insured fails to comply with its contractual notice obligations
  - circumstances in which the insured is reluctant to report losses that might adversely affect its loss experience and renewal premiums, and
  - insurance relationships in which the insured by agreement has the right or obligation to handle and pay claims. Accordingly, insurers may have insufficient information to report such claims, undermining CMS's interest in timely reporting and giving rise to disputes. We encourage CMS to reconsider its assignment of reporting obligations with respect to claims payments made by insureds.
- **The Ever Broadening Definition of No-Fault Insurance:** According to the updated User Guide, "Med Pay", "Personal Injury Protection (PIP)", "Accident & Health", "Short Term Travel", and "Occupational Health" products all give rise to reportable claims payments because they fall under the broader

category of "no-fault insurance", as that category of insurance is defined by the MSP regulations. This guidance fails to take into account the wide variety of policies offered under these or similar policy names and the substantial differences in coverage, many of which would not, under any circumstances, appear to trigger Section 111 reporting obligations or MSP reimbursement within the relevant statutory terms and regulations. Nor does the guidance offer any definition of these policy types.

Many policies that may be known colloquially by these general product terms may actually be individually issued health policies, outside the reach of Section 111 reporting obligations. For example, travel policies often offer individual health coverage, which is not triggered by accident or injury, and thus does not fall within the definition of no-fault insurance under MSP law. Furthermore, these policies also do not qualify as group health plans (GHPs), which have a separate Section 111 reporting scheme. As with CMS's revised RRE guidance for insureds with deductibles (discussed above), we anticipate that this guidance on "no fault" policies is likely to generate a significant number of disputes in the absence of further clarification in the User Guide.

- **"Foreign" RRE Registration:** CMS's new guidance in this area is most striking for what it does *not* address. While it may solve the technical issues that have arisen regarding how and when an overseas insurer should register if it does not have a (previously required) U.S. address or Taxpayer Identification Number (TIN), the guidance has yet to answer the more fundamental questions that overseas entities have raised with CMS, such as whether U.S. law, specifically Section 111, can reach their businesses and policies, particularly if those policies are written on overseas paper covering the risks of overseas insureds with minimal or no U.S. contacts.

    - The first date that overseas insurers may resume registration with CMS is April 5, 2010, but they are not *required* to be registered by that date.
    - Delay in the foreign insurer registration date does not change the requirement that foreign insurers, like domestic insurers, must begin reporting in the first quarter of 2011, and does not change the retroactive reporting requirements for ORM and TPOC claims settlements and other payments made since January 1, 2010 and October 1, 2010, respectively.
    - Overseas insurers will use a "pseudo-TIN" of 9999xxxxx, where "xxxxx" is any 5-digit number created by the RRE. This number will be used in place of a TIN, which all other insurers must use in the registration process.
    - CMS Guidance does not state whether the registration system will permit two separate RREs to use identical 5-digit numbers, or whether attempted combinations will be rejected until a unique 5-digit identifier is created.
    - Overseas insurers are encouraged by CMS to make every effort to supply U.S. addresses and telephone numbers for the Claimant and Representative fields. If none is available, CMS has instructed RREs to put "FC" in the State Code field and default all other fields to spaces or zeroes. In addition, CMS has advised that the COBC may contact an RRE directly for additional claimant

and representative information.

- In one of the most recent Alerts, CMS committed to issuing further, albeit undefined, guidance regarding foreign insurer reporting under Section 111.

- **Changes to RRE Registration and Reporting:** CMS has added a new section to the User Guide that provides instructions for RREs that abandon their IDs, cease reporting, and/or need to change RRE information.
- **Valid ICD-9 Diagnosis Codes:** The revised User Guide provides instructions for downloading text files of the ICD-9 codes that CMS considers valid. For example, V codes may no longer be submitted.
- **Medicals Claimed and/or Released:** If medical expenses are claimed and/or released, CMS expects the settlement, judgment, award, or other payment to be reported under Section 111, even if there is no admission or determination of liability; however, insurers are not required to report "property damage only" payments, if the claimant did not demand payment for medical expenses *and* the settlement or payment did not release, or have the effect of releasing, liability for medical expenses.
- **Subsidiaries:** Supplying subsidiary information at registration is now optional for RREs.
- **Fronting Policies:** The Alert titled "Who Must Report" clarifies CMS's understanding of fronting relationships between insurers and insureds. The Alert states, "The intent with 'fronting' policies is that the insurer will not ultimately retain any risk under the insurance policy. . . . [Thus,] where the insured pays a claim, the insured is the RRE. Where the insurer pays the claim, the insurer is the RRE."
- **Self-insurance pools:** In the Alert titled "Who Must Report," CMS clarifies existing guidance regarding self-insurance pools and carved out an exception to the rule that the self-insurance pool can only serve as the RRE if it: (1) is a separate legal entity, (2) with full responsibility to resolve and pay claims using pool funds, and (3) there is *no involvement* of the participating entities. The Alert also identifies the self-insurance pool as the RRE "where the statute authorizing the establishment of a self-insurance pool stipulates that said self-insurance pool shall be licensed and regulated in the same manner as liability insurance (or workers' compensation, where applicable)", *even if* the other three requirements are not met. In addition, the Alert reminds insurers that if the individual members of a self-insurance pool are the designated RREs, they may choose to designate the pool as their reporting agent, although they will still retain ultimate responsibility for compliance with the statute.

Our Section 111 Team routinely monitors CMS 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.