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# Section 111 Bulletin: June 30th NGHP Town Hall Teleconference: Confusion and Uncertainties over Deductibles Continue; No Progress on Significant Issues Awaiting Clarification

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On June 30, 2010, the Centers for Medicare & Medicaid Services held a teleconference for Non-Group Health Plans (NGHPs) focusing on policy issues related to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Much of the notable discussion related to the identification of the proper Responsible Reporting Entity (RRE) when the policyholder pays a deductible or self-insured retention, and underscored problems with the application of CMS's earlier guidance on the same subject. Otherwise, the teleconference added relatively little to existing Section 111 guidance, primarily highlighting issues yet to be addressed by the Agency and revisiting well-worn issues for latecomers to Section 111. Among the topics discussed were:

**Deductibles:** CMS's February 24, 2010 Alert that replaced Section 7.1 of the NGHP User Guide, and which was later revised in a May 26, 2010 Alert, continues to generate confusion and concern and was the subject of several exchanges during the call. (You may read our summary of this earlier guidance in our Bulletins of February 26, 2010 and March 4, 2010.) CMS has done little to clarify the ambiguities in this guidance, and one portion of the town hall discussion served to highlight its inherent flaws:

- **Distinction Between Deductibles and SIRs.** Comments from CMS and from at least two insurers during the June 30

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teleconference confirmed that the terms "deductible" and "self-insured retention" (SIR) are not used consistently by insurers, brokers and insureds. CMS's February Alert defines "deductible" as the "risk the insured retains with respect to the coverage provided by the insurer", and "self-insured retention" as the "risk the insured retains that is not included in the coverage provided by the insurer". However, a discussion of a hypothetical, which began with an inquiry regarding "excess insurance" and a "$1 million policy with a $500,000 SIR" and culminated with CMS's conclusion that the hypothetical involved a deductible rather than an SIR, underscores the continuing confusion on this subject. Indeed, it is unclear whether the caller with the inquiry and the CMS representatives ever reached a meeting of the minds regarding the facts of the hypothetical.

- **Payments "Without Recourse."** The guidance in CMS's February Alert on RRE selection also turns on the meaning of the phrase "without recourse to insurance" but fails to explain the intended meaning and scope of "without recourse" payments. CMS comments during the teleconference, stating that "without recourse" means that the insured is not "operating within the bounds of" the insurance agreement (*e.g.,* by not reporting the claim to the insurer), may offer some limited insight into CMS's views. Unfortunately, the colloquy did not resolve other basic questions about the reach of the "without recourse" standard, such as possible application to situations in which the insured initially withholds notice and subsequently provides late notice to the insurer (in some cases a year or more after the event). Obviously, in those situations, it would be impossible for the insurer to provide what CMS is likely to define as timely reporting by an RRE.
- **Deductible Policies Involving Deferred Reporting.** CMS's response to a question regarding policies subject to deductibles, under which the insured by agreement handles the defense, settlement and payment of claims and is required to report claims payments to the insurer only after the fact, presents in stark relief the unrealistic and unworkable nature of the Agency's February Alert guidance. In the teleconference, CMS took the position that the insurer would still be the RRE in this scenario, and would have to obtain the information from the policyholder (notwithstanding the fact that under existing contractual arrangements, such information would not be reported to the insurer until the end of the annual policy term). The claims-handling arrangements in question presumably were designed to reduce premiums and administrative costs by permitting the policyholder to handle its own claims and to limit the costs of exchanging information with the insurer, but the approach outlined by CMS would undermine those goals. It is doubtful whether CMS has any regulatory authority to require reporting by the insurer in this context, in which the insurer has not paid any claim or acknowledged any coverage obligation and may not even have been notified of the existence of the claim. We anticipate that disputes are likely to arise between insurers and CMS, if the Agency persists in this view.

**Revisions and New Alerts:** CMS advised that it is revising both the *Clinical Trials* and the *Risk Management Write-Offs* Alerts, released in May, in response to requests for clarification. CMS representatives also announced that an Alert on cumulative trauma issues should be posted to the Section 111 website soon, and it will likely define the Date of Incident (DOI) as the date on which a condition was first diagnosed or first treated.

**Risk Management Write-Offs:** In response to a question asked during the teleconference, CMS clarified that the first two bullet points (of three) and related guidance in the second half of the *Risk Management Write-Offs* Alert apply to providers, physicians and other suppliers that have the obligation to factor in and thus identify reduced charges or write-offs when preparing their billing statements, while the third bullet point refers only to entities other than providers, physicians and other suppliers. CMS also stated during the teleconference that the Agency plans to look more closely at how "Never-Events" may affect risk management write-offs, so we may hear more about this topic in the future.

**Judgments Exceeding Policy Limits:** If a judgment is rendered on behalf of a Medicare beneficiary against any entity engaged in a business, trade or profession, and the judgment exceeds the insured's policy limits, the insured will be liable for paying the excess amount. The insured is self-insured for this purpose and will have to register as an RRE and report the payment to CMS under Section 111. CMS clarified that this does not mean that *all* entities engaged in a business, trade or profession need to register as an RRE preemptively. Entities only must register if they reasonably anticipate having claims to report. If an entity does not anticipate having more than 500 reportable claims a year, it can register and report such payments through the new direct data entry (DDE) system when such a situation arises.

**Settlements with Medicare Advantage Beneficiaries:** CMS advised that NGHPs making payments to Medicare Advantage plan beneficiaries are required to report these payments under Section 111 because there is a chance the beneficiaries could have transferred in and out of available Medicare programs and that the NGHP payment could have been made while the person was in the fee-for-service (or "original" or "Parts A and B") Medicare program. We note that if the claimant has never been enrolled in Medicare Part A or B and has only been a Medicare Advantage (Part C) beneficiary since becoming Medicare eligible, Section 111 reporting is not designed to report NGHP payments to this individual. Any coordination of benefits activities would be handled by the Medicare Advantage plan, not CMS.

**Translations of Model Language Form:** CMS stated that if entities want to translate certain documents issued by CMS into another language (*e.g,* the Model Language Form CMS encourages insurers to use to obtain Health Insurance Claim Numbers (HICNs) or Social Security Numbers (SSNs) from claimants), the entity should submit the translated document to CMS, and the Agency will review and approve the translation if it meets Agency standards.

**Loss of Consortium Claims:** The Agency indicated, in response to caller questions, that payments solely compensating Medicare beneficiaries for loss of consortium must always be reported if the settlement contains a release for medical expenses, whether or not medical services were provided. This holds true whether the injured party is the Medicare beneficiary and his or her non-beneficiary spouse is claiming loss of consortium, or vice versa, where the Medicare beneficiary is claiming loss of consortium due to the non-beneficiary spouse's injury. CMS is interested in receiving such a report because if the compensated spouse would later seek related medical services (*e.g.,* possibly mental health services), Medicare would be the secondary payer behind the insurance payment.

**Overseas Insurers:** CMS did not report on the status of its pending guidance regarding overseas insurers that are "doing business" in the United States and therefore must report under Section 111, despite the fact that the registration process for overseas insurers opened again on April 1, and overseas insurers are expected to follow the same reporting procedures (and presumably, the same reporting schedule) as domestic RREs.

**Mass Torts:** CMS answered a few questions regarding the December 5, 1980 exposure liability cut-off date, but indicated that continuing ambiguity and uncertainty about how this date affects reporting requirements will be the focus of the anticipated Mass Torts working group call, which is yet to be scheduled.

**Future NGHP Teleconferences:** CMS is planning additional NGHP teleconferences through the rest of the year and expects to post a schedule on the Section 111 website within the next couple of weeks. There will be only one NGHP teleconference per month in July and August, and each call will deal with both policy and technical reporting issues. The July call is tentatively scheduled for July 28. From September forward, CMS plans to hold two NGHP calls per month, one focusing on policy issues and one on technical reporting.

Our Section 111 Team routinely covers the Section 111 NGHP 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 the transcripts back to October 2008. Please let us know if you would like more information about any of the topics discussed during the June 30, 2010 call. You may also access our Section 111 webpage and the other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.