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ALERT

Section 111 Bulletin: CMS Confirms Another Delay Of Section 111 Reporting For "Certain" Claims Payments But Major Issues Remain Unsettled

October 5, 2011

On September 30, 2011, the Centers for Medicare & Medicaid Services (CMS) announced another delay, applicable only in limited circumstances, to mandatory insurer reporting under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). The new deadlines will apply only to select liability insurance (including self-insurance) settlements, judgments, awards, or other payments under specific dollar thresholds. The details of the delay were not available until over the weekend when CMS posted its Alert. CMS also released three other guidance documents addressing Exposure, Ingestion, and Implantation Issues and December 5, 1980; Future Medicals; and Qualified Settlement Funds.

Reporting Timeline Extended for Lower Value Claims

CMS has again delayed mandatory insurer reporting for certain liability insurance "TPOC" payments (reflecting a total payment obligation to a claimant) under $100,000, offering a revised timeline that spreads the new dates out over a year based upon a sliding scale of "TPOC amounts." Because Responsible Reporting Entities (RREs) are free to commence reporting at any time, the revised dates correspond to the dates by which reporting *must* begin or the RRE risks imposition of a $1,000 a day statutory fine.

Insurers were forced to request a fourth extension to the mandatory reporting timeline because numerous questions remained unanswered concerning RRE reporting obligations, particularly

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obligations arising out of mass tort settlements. The grant of additional time to report TPOC amounts under $100,000 is unlikely to assuage the concerns of liability insurers as there has been little progress on, and virtually no further discussion concerning, the issues tied to mass tort litigation. Further, CMS does not seem to recognize that an accurate estimate of the likely future TPOC amounts for claims presented against a defendant (or policyholder) is often not available until after substantial discovery has been completed and/or serious settlement discussions are underway. Insurers with a high claims volume will still need to monitor and analyze all claims for possible reporting obligations.

The revised reporting timeline is as follows, as presented by CMS in its Alert: **TPOC Amount TPOC Date On or After Section 111 Reporting Required in the Quarter Beginning** TPOCs over $100,000 Oct. 1, 2011 Jan. 1, 2012 TPOCs over $ 50,000 Apr. 1, 2012 July 1, 2012 TPOCs over $ 25,000 July 1, 2012 Oct. 1, 2012 All TPOCs over minimum threshold Oct. 1, 2012 Jan. 1, 2013

In the Alert, CMS gives the longest extension to TPOC amounts valued under $5,000, the current "minimum threshold" below which no reporting is now required until January 1, 2013, when the minimum threshold amount decreases to $2,000. Although this extension may address a large volume of claims, it provides no relief for higher value claims payments. Further, in the most challenging case management/settlement allocation situations involving global settlements, TPOC amounts may not be known until the eve of payment, and/or the TPOC amounts may vary sufficiently among claimants in one mass tort action such that some TPOC amounts will fall into the category for which no extension has been granted while other TPOC amounts will be granted an extension (*e.g.,* settlement of a group of asbestos claims against a policyholder where claimants' alleged injuries include asbestosis, mesothelioma, pleural plaques, etc.). CMS has shown little appreciation for the sophistication of the industry's concerns about the application of Section 111 to such complex claims scenarios.

Some RREs are asking whether the new TPOC amounts should be applied separately to each payment an insurer makes to a claimant, to each payment an insurer makes on behalf of a particular defendant to a claimant, to the total payments an insurer may make to a claimant, or to the total payments multiple insurers may make collectively to one claimant in one lawsuit. These questions are not answered by the Alert.

The Alert advises readers instead to refer to the latest version of the Non-Group Health Plan (NGHP) User Guide for a fuller "explanation of TPOC." Section 11.10 of the User Guide states: "[t]imeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the date there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary." (Emphasis added.) User Guide Section 11.10 also recommends that readers "remember that a single payment obligation is reported as a single aggregate total (one TPOC amount) regardless of whether it is funded through a single payment, an annuity or a structured settlement. However, the sum of all TPOC amounts must be used when determining whether the claim meets the applicable reporting thresholds." (Emphasis added.) Finally, the same User Guide Section states that: "[f]or a settlement, judgment, award or other payment *with joint and several liability*, each RRE must report the total settlement, judgment, award, or other payment-not just its

assigned or proportionate share." (Emphasis added.)

Many questions have been raised in Section 111 town hall teleconferences concerning the meaning of the requirement that "[f]or a settlement, judgment, award or other payment with joint and several liability, each RRE must report the total settlement, judgment, award, or other payment-not just its assigned or proportionate share." The recent guidance does not address insurers' prior requests for clarification of this statement.

Exposure, Ingestion, and Implantation and December 5, 1980

On April 14, 2011, CMS held a conference call with the Section 111 "Mass Torts" working group regarding draft guidance on exposure, ingestion and implantation issues, as well as the application of the December 5, 1980 effective date of the Medicare Secondary Payer (MSP) statute. Despite promising to schedule future calls and release final guidance within four to six weeks, CMS has not held another working group call since April and has only now issued final guidance on these issues.

The final guidance states that CMS will not assert an MSP recovery claim against settlements, judgments, awards or other payments where the date of incident is prior to December 5, 1980, the effective date of the MSP statute. CMS's guidance emphasizes that it will focus on the date of last exposure or ingestion for determining whether the exposure or ingestion occurred on or after December 5, 1980.

The final guidance also states that "Medicare will assert a recovery claim" (emphasis in original) where exposure, ingestion or the alleged effects of an implant on or after December 5, 1980 are "claimed, released, or effectively released," but then carves out the circumstances described below.

Specifically, CMS promises that it will not assert a recovery claim, and Section 111 reporting is not required, where all of the following criteria are met:

- All exposure or ingestion ended, or the implant was removed, before December 5, 1980; and
- Exposure, ingestion or an implant on or after December 5, 1980 has not been claimed and/or specifically released; and
- There is either no release for the exposure, ingestion or an implant on or after December 5, 1980; or where there is such a release, it is a broad general release (rather than a specific release), which effectively releases exposure or ingestion on or after December 5, 1980. The rule also applies if the broad general release involves an implant.

Importantly, although CMS first states that it will assert a recovery claim where exposure on or after December 5, 1980 is "effectively released," the criteria above specifically carve out from reporting and recovery the situation where there is no known or alleged exposure after December 4, 1980 *but simply* the presence of "a broad general release . . . which effectively releases exposure or ingestion on or after December 5, 1980." Although the Alert references exposure being "effectively released" in both places and therefore creates some uncertainty, it appears the intent is for the more specific language set forth in the three criteria in the bullet points above to control over the less specific statement that precedes it.

Carving out any situation where there is a "broad general release (rather than a specific release)" is a significant development and advancement from earlier discussions about how CMS will handle situations with known and alleged exposure only before the December 5, 1980 date. It would seem to suggest that the common practice of incorporating general releases into settlements should not itself trigger reporting obligations and MSP recovery claims for situations involving no known or alleged exposure, ingestion or implantation on or after December 5, 1980. It also may signal that CMS will not look at general releases in other claims situations as sufficient to pull an insurer into Section 111 reporting, for example in the context of settlement of a Professional Liability claim, where unalleged claims for emotional distress may be encompassed in a general release.

The CMS guidance does not expressly address insurer objections to applying the MSP statute and Section 111 obligations to payments made under liability policies that expired prior to December 5, 1980. To the extent that CMS intends to extend MSP reimbursement and Section 111 reporting to payments made under such policies, the Agency position would appear to contravene the terms of the MSP statute, Section 111, and prior law in effect through December 4, 1980 that identified Medicare-not private liability insurance-as the primary payer. Neither the MSP statute nor Section 111 appears to authorize retroactive application of the MSP statute to insurance contracts with expiration dates prior to December 5, 1980. The fortuitous existence or allegation of post-1980 exposure in a claim should not have the effect of extending MSP or Section 111 obligations to an insurer that pays an amount predicated upon exposure within a policy period that expired prior to the December 5, 1980 effective date of the MSP statute. This issue is likely to spawn continuing contention and potential litigation between insurers and CMS, unless the Agency addresses the issue and eliminates any "reach-back" to pre-December 5, 1980 policies. Perhaps CMS will be asked to discuss these long unanswered questions in the next CMS teleconference, currently scheduled for October 19, 2011, as a prelude to providing necessary guidance.

Qualified Settlement Funds

CMS announced a limited reporting exception for funds that have been paid before October 1 of this year into a Qualified Settlement Fund (QSF). Section 111 reporting is not required if all of the following criteria are met:

- The settlement, judgment, award or other payment is a liability insurance (including self-insurance) TPOC amount, where there is no Ongoing Responsibility for Medicals (ORM) involved; and
- The settlement, judgment, award or other payment will be issued by a QSF under Section 468B of the IRC, in connection with a State or Federal bankruptcy proceeding; and
- The funds at issue were paid into the trust prior to October 1, 2011.

This guidance provides some much-needed relief with respect to funds paid by insurers into bankruptcy trusts where insurers generally neither control the settlement process nor have access to the information regarding the claimants and settlements that would be necessary for Section 111 reporting. The guidance provides no relief, however, with respect to any settlement, judgment, award or other payment issued by a QSF where the

funds at issue were paid into the trust on or after October 1, 2011.

The Alert does not address serious questions as to whether the MSP statute and Section 111 can be construed to trigger *any* reimbursement or reporting obligations on the basis of payments made to QSFs or any other payments that are made without regard to specific claims (such as payments made pursuant to coverage buy-back agreements with policyholders). These important questions appear likely to remain for resolution by the courts. In the interim, the CMS guidance on QSFs poses substantial issues about how responsibilities for reporting and MSP liability will apply to pending cases, such as bankruptcy proceedings where there are active appeals challenging the approval of plans involving the creation of a trust that is intended to qualify as a QSF but which may not be funded pending resolution of appeals. Looking ahead, the limitations in this CMS Alert may delay or deter the establishment and funding of further QSFs in bankruptcy proceedings, as well as the conclusion of coverage "buy-back" agreements between insurers and policyholders, pending efforts to address difficult issues regarding control of future settlements with claimants and access to reporting information.

Future Medicals

Of somewhat less import to insurers, CMS released guidance instructing Medicare beneficiaries that receive liability settlements, judgments or other payments to obtain a certification from their treating physician if treatment for the alleged injury related to the liability claim has been completed as of the date of the settlement. In such a situation, CMS advises that Medicare would consider its interest, with respect to future medicals, satisfied. It is not clear how the certification process contemplated by CMS would work in practice; however, this guidance does not directly affect a liability insurer's obligations under Section 111 and the MSP statute. As CMS has clarified on numerous occasion, insurers have no obligation to enter into Medicare set aside arrangements or otherwise ensure that a Medicare beneficiary depletes settlement funds before requesting Medicare benefits for future health care services. A liability insurer's obligation to protect Medicare's interests is limited under the MSP statute to fulfilling its obligations as a primary payer and reimbursing Medicare for conditional payments. Any obligation to protect Medicare's interests with respect to the payment of a Medicare beneficiary's future medical expenses rests upon the beneficiary.

Other Announcements

CMS announced that a new automated self-service feature became available on the Medicare Secondary Payer Recovery Contractor (MSPRC) phone line on September 30, 2011, enabling callers to receive up-to-date conditional payment information without speaking to a customer service representative. It remains to be seen whether CMS will address such issues as who may access the new automated feature and what security features will be employed to protect the confidentiality of the released information. CMS also states on its website that beginning this month, CMS will implement an option by which insurers may pay a fixed percentage of certain physical trauma-based liability settlements of $5000 or less, ostensibly as reimbursement for Medicare conditional payments. CMS promises to release an Alert on this topic on or before October 21, 2011.

Finally, CMS promises the following program improvements within the next three to nine months:

- "The implementation of a MSPRC portal, where the beneficiary/representative can obtain information about Medicare's claim payments, demand letters, etc., and input information related to a settlement, disputed claims, etc."
- "The implementation of an option that allows for an immediate payment to Medicare for future medical costs that are claimed/released/effectively released in a settlement."
- "The implementation of a process that provides Medicare's conditional payment amount, prior to settlement in certain situations."

*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.*