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ALERT

Section 111 Bulletin: March 16, 2010 Town Hall Teleconference Overview: CMS Takes Stock of Its To-Do List

March 17, 2010

On March 16, 2010, the Centers for Medicare & Medicaid Services (CMS) held its monthly teleconference for non-group health plans (NGHPs) that focuses on policy issues related to the implementation of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Some of the issues CMS addressed included:

- **Foreign Insurer Reporting:** CMS stated that in the forthcoming foreign insurer alert, CMS will address not only *how* foreign insurers without a U.S. address and TIN will register and report, but also *which* of these entities need to report in the first place and how to reconcile certain privacy issues. Based on our own experiences, we infer CMS to be alluding to issues of conflict between EU privacy law and Section 111.
- **Low Volume Reporting:** Insurers that have a very low volume of reportable claims payments may be able to report through a web-based DDE modality, which will be described further in guidance that CMS hopes to release within the month. In response to a question from the audience, a CMS representative stated that it was safe for insurers with perhaps only five reportable claims per year to wait until this guidance was released before taking any action to prepare for Section 111 reporting. CMS apparently is still deciding how many claims per year will constitute "low volume" sufficient to qualify for this less resource intensive option, and is working with the IT Team to establish an implementation date.
- **Reporting Exception for Errors and Omissions:** CMS confirmed that it is still considering a reporting exemption for

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claims paid under "E&O" policies. Whether CMS meant to include D&O policies or other PL lines in this brief comment was not clear, but it would make good sense for CMS to review the burden placed by Section 111 on other PL lines also unlikely to give rise to many reportable claims payments. Indeed, under most PL lines, typically very few, if any, settlements involve claims for medical expenses, even though such settlements may include general releases.

- **The Pitfalls of General Releases:** In response to several insurer questions, CMS advised that the insurer would need to report a settlement payment if the insurer received a general release, even if the release did not expressly release claims for medical expenses, and even if the claimant had not made a claim for medical expenses. We note that CMS has not addressed this question in the context of coverage that excludes payment for medical expenses.
- **Large Deductible Insureds:** In response to another question posed by a caller, CMS reaffirmed that while insurers could not shift Responsible Reporting Entity (RRE) obligations to insureds with large deductibles, they may set up multiple RRE IDs and have their insureds with large deductibles act as reporting agents (account managers) for their own claims. Such insureds would need to agree to accept the reporting burden, but the insurer would still maintain the ultimate responsibility for Section 111 compliance.
- **Bad Faith Claims Under State Law:** Several callers raised questions or asked for safe harbor guidance to ward off a growing number of threatened bad faith claims against insurers that request personal information from claimants in order to comply with Section 111 and meet any MSP obligations, including obtaining SSNs or HICNs from claimants. Some plaintiffs have argued that such efforts by insurers to comply with Section 111 reporting obligations could constitute an impermissible condition on settlements or claims payments in violation of state claims handling laws, although other commentators do not agree with those assertions and, indeed, a construction of state claim handling laws that would prevent compliance with federal law under Section 111 could raise significant federalism concerns. CMS representatives offered no guidance in response to these questions but requested that any interested parties submit safe harbor suggestions to the resource mailbox at PL110-173SEC111-comments@cms.hhs.gov.
- **TPOC (Total Payment Obligation to the Claimant) Reporting Dates:** CMS stated that the agency is considering new guidance that would permit insurers to delay reporting TPOC amounts until they know the exact amount they will pay the claimant and funds are available for payment. For example, execution of a settlement agreement might not trigger reporting if payment were not to be made until the next quarter. CMS acknowledged that this practice would virtually eliminate the use of the delayed funding field on the Claim Input File Detail Record.
- **Mass Torts Payments and December 5, 1980 Cut-Off Date:** CMS offered that there had been no meeting of the mass torts working group for more than two months, and that it does not know if it will reconvene the group before the agency issues further reporting guidance (supposedly addressing such issues as (i) which entities must report when there are multiple insurers contributing to a settlement fund and no allocations of individual insurer payments to any specific claimants, and (ii) if all exposure predates 12/80 but the insurers receive a release for post-12/80 medical expenses, must the insurers

report?). CMS also reported that it would accept proposed solutions for reporting scenarios through the resource mailbox.

- **Subscription Policies:** CMS stated that it had received requests for further guidance on reporting obligations when multiple insurers appear on a subscription slip, accepting risk in differing percentages or amounts. CMS invited insurers to help them flesh out issues by writing in to the resource mailbox with specific questions, appearing to question why current guidance was insufficient for purposes of RRE identification. We note that insurers may be asking broader questions, such as who reports when an insurer does not have access to claimant information, as is common in certain mass torts scenarios.
- **Medicare Set Asides:** CMS reiterated that Medicare set aside arrangements are not required but advised settling parties to make "appropriate arrangements for the exhaustion of settlement funds," citing the MSP statute, which requires Medicare to pay a beneficiary's claims for medical expenses on a secondary basis when an insurer also pays medical expenses. Any risk of failing to exhaust such funds, presumably on medical expenses, would appear to fall on the Medicare beneficiary, whose future claims CMS has said it may then deny.
- **Periodic Payments and Clinical Trials:** CMS indicated that these Alerts were currently "in clearance", implying that they might be released soon.
- **Revision to the February 24 "Who Must Report" Alert:** CMS stated that it still intends to revise the definition of "liability self-insurance" as it appears in Appendix G to the User Guide to conform to the definition in the Alert. More specifically, we understood CMS to be saying that it intends to delete the second paragraph of the definition in Appendix G.

Our Section 111 Team routinely covers the Section 111 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 teleconference transcripts back to October 2008. Please let us know if you would like more information about any of the topics discussed during the March 16, 2010 call. You may also access our Section 111 webpage and the Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.