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Medicare and the Confusion over Insurer Reporting

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The Centers for Medicare & Medicaid Services (CMS) faced an increasingly frustrated group of liability insurers during its Nov. 16, 2011, town hall teleconference for Nongroup Health Plans (NGHPs) on technical issues associated with insurer reporting under Section 111 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007.

Several callers complained about widespread Medicare claim denials experienced by Medicare beneficiaries receiving liability insurer payments, and there were many questions about the ongoing confusion related to the amount that responsible reporting entities (RREs) should report when a settlement is funded by multiple defendants or insurers.

CMS's answers provided little clarity on these issues.

Moreover, CMS and representatives from its Coordination of Benefits Contractor (COBC) implicitly blamed RREs for coding problems that in large part derive from ill-conceived elements of the Section 111 reporting scheme or from performance deficiencies of CMS and its contractors.

There was scant evidence that CMS has made any substantial progress in addressing fundamental reporting issues that continue to plague Medicare beneficiaries, counsel for both plaintiffs and defendants in tort cases, and insurers and self-insured entities.

Medicare's Widespread Denials of Claims

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Numerous callers expressed their concern and frustration over Medicare's increasingly frequent denials of claims for Medicare beneficiaries for care that is unrelated to the disease or injury compensated or released by a reported tort settlement.

A COBC representative may have attempted to shift some responsibility for these Medicare claim denials to liability insurers, contending that RREs must ensure that they identify the correct ICD-9 codes for their Section 111 reports and not adopt unrelated or incorrect codes from beneficiary medical records.

Insurance companies, however, are ill-equipped to perform this task. Their claim personnel typically are not trained medical experts, and while some claim personnel may be familiar with ICD-9 codes, they often lack access to detailed medical records and information that would be necessary to perform the oversight or corrective actions possibly envisioned by CMS and the COBC.

In addition, the ICD-9 coding system was not designed for liability insurer use, and, as CMS has conceded, there often may not be a perfect match between available codes and the specific disease or injury that is the subject of a tort claim.

Furthermore, Medicare's inappropriate denials of claims are taking place even where the ICD-9 codes contained in a Section 111 report accurately reflect RRE compensated or released injuries.

Indeed, a COBC representative on the teleconference acknowledged that there have been reports of inappropriate claim denials even where RRE(s) have reported only accurate ICD-9 codes. This was confirmed by several callers who reported that Medicare beneficiary claims were denied for services unrelated to the diagnosis codes reported by the RRE.

For example, it appears that Medicare beneficiaries with open ongoing responsibility for medicals (ORM) claims-referring to claims for which the insurer has an ongoing responsibility to pay the individual's medical expenses-are being categorically denied benefits for all services and told to speak with the applicable liability insurer about terminating the ORM so they can receive Medicare benefits.

CMS representatives stated that the agency is working to resolve this issue, but there have been public complaints about claim denials for some time now, and anecdotal evidence suggests the problem may be getting worse.

For example, Ilene Stein, a representative from the Medicare Rights Center, described several examples of beneficiary claim denials during a June 22, 2011, congressional hearing on issues related to the Medicare Secondary Payer recovery process.

During the teleconference, Peter Foley, vice president of claims administration at the American Insurance Association, stated that members of his organization are aware of claim denials across the country and are

concerned because Medicare beneficiaries may believe the property and casualty industry is responsible for the inappropriate denials.

AIA is recommending that its members, as well as Medicare beneficiaries, contact their congressional representatives to raise awareness about the problem and seek appropriate relief. Insurers do not cause Medicare's inappropriate denials of beneficiary claims, and they are not responsible for curing systemic Medicare claims processing errors.

Reportable TPOC Amount for Claims Involving Multiple RREs

The teleconference further muddied CMS's ambiguous and inconsistent guidance regarding the appropriate total payment obligation to the claimant (TPOC) amount to be reported with respect to claims involving multiple RREs.

Indeed, over the course of the teleconference, the CMS and COBC representatives appeared to disagree at times with respect to the proper application of some aspects of CMS's guidance, highlighting the agency's lack of clarity on this subject.

Moreover, CMS comments suggest that the agency's views may be influenced by fundamental misunderstandings regarding typical settlement practices in large tort cases implicating multiple insurers, as well as the concept of joint and several liability as applied to such settlements.

CMS guidance in this area turns, at least in part, on the existence of joint and several liability. That guidance is unclear in part because:

- It does not clearly distinguish between the potential joint and several liability of co-defendants in tort actions and the potential coverage liabilities of insurers, including multiple insurers for a single underlying defendant;
- It does not expressly address the typical settlement scenario in which, regardless of whether the underlying claimant has alleged joint and several liability, the settling defendant or defendants typically deny any liability whatsoever – joint and several or otherwise – but compromise the claim to avoid litigation expense, inconvenience and risk;
- It does not grapple with the fact that, in the majority of cases, insurers are not parties to the settlement agreement; and
- It does not address the many limitations on potential insurer liability, including coverage defenses, policy limits and cost-sharing agreements or other agreements that limit the insurer's share of any payment to an amount less than the total settlement with the claimant.

During the teleconference, a COBC representative addressed a question from a liability insurer regarding the amount to be reported when multiple insurers will be paying a portion of a defendant's settlement or judgment.

The COBC representative stated that if the amount owed by each insurer was "clearly defined," the TPOC amount reported by each insurer should be the amount of each insurer's individual payment.

By contrast, Barbara Wright, a representative for CMS, asserted that "clearly defined" was not necessarily the appropriate terminology, as there could be clearly defined allocations in a joint and several liability situation where the entire amount of the settlement or judgment would, nevertheless, need to be reported.

She added that if each insurer had a "separate settlement," each insurer would report only the amount of its payment. In response to a later question about TPOC amounts, Wright repeated her statement that the determinative issue is whether there is a joint settlement with joint and several liability, or whether there are separate settlements.

She also noted that it is important to look at "how the settlements are done." Wright then noted that CMS is "concerned about [receiving] full data" and is "not interested in duplicative data." She concluded by stating that the reportable number(s) will need to be worked out individually in each scenario.

These comments from CMS and COBC during the teleconference fail to resolve the ambiguities noted above.

For example, Wright's comments appear to suggest that CMS believes that insurers routinely are parties to tort settlement agreements, which is not the case.

In the context of a settlement or judgment that includes multiple defendants, CMS's comments fail to address the fact that an insurer for one defendant has no obligation to pay any liability imposed upon another defendant that is not insured under the policy.

In the context of multiple carriers that insure a single defendant, CMS's view does not explain how the joint and several liability rubric would ever apply to insurers who each issued separate insurance policies, subject to their own terms and limitations, to the defendant.

For example, in the simplest scenario involving a primary carrier and an excess carrier, the primary carrier has no obligation to pay any amount in excess of its policy limits, even if the defendant and excess carrier are unable to pay the amount in excess of limits. Conversely, the excess carrier typically has no obligation to pay any amount below the attachment point of its excess policy.

Does CMS expect both carriers to report the entire amount of the settlement or judgment in that scenario-assuming the excess carrier paid the claimant directly and thus had a reporting obligation-despite the fact

that neither could be compelled to pay the entire amount to the claimant?

Similarly, in a scenario in which multiple insurers issued policies to a defendant providing coverage in separate, discrete policy periods, which is often the case in long-tail claims involving exposures over a period of several years, a particular insurer often has entered into a settlement or coverage-in-place agreement with the policyholder, or a cost-sharing agreement with the policyholder and other carriers, that resolves coverage disputes and uncertainties and limits the insurer's obligation to a specific amount or a specific allocated share of any settlement or judgment.

A similar limitation to the insurer's pro rata, allocated share may apply pursuant to policy terms and applicable law, even in the absence of such a coverage settlement or cost-sharing agreement.

Does CMS expect each carrier to report the entire amount of the settlement or judgment in that scenario, even though no insurer could be compelled to pay the entire amount, or, alternatively, does CMS expect each carrier to report only the amount for which it is liable?

Regrettably, the teleconference comments and prior CMS guidance do not answer any of these questions. In the face of uncertainty, some insurers appear to have concluded that the conservative approach is to report the entire amount agreed between the defendant and the claimant, on the theory that the CMS guidance is hopelessly muddled and that an insurer could never be faulted for reporting the larger amount.

Other insurers appear to have concluded that it makes more sense to report the amount actually paid by that insurer, reasoning that the concept of joint and several liability does not apply in these scenarios and that CMS's approach to this question appears to be based upon a non sequitur.

The consequences of this uncertainty are likely to fall most heavily upon claimants, some of whom are likely to receive erroneous denials of Medicare coverage from CMS because CMS will have misleading data suggesting that the total TPOC amount paid on a claim is larger than the actual total payment received by the claimant.

CMS and its contractors will face heavy administrative costs attempting to figure out, on the "back end," the total amount actually paid to the claimant, and may face a political backlash as the number of frustrated Medicare beneficiaries and insurers mounts.

A better and simpler solution would be to require each RRE to report only the amount that it paid, but there is little time for CMS to make that clarification before more RREs begin to report in the first quarter of 2012, and there is no evidence that the agency intends to fix the deficiencies in its current guidance.

Accuracy of Beneficiary Look-Up Tool

CMS also acknowledged during the teleconference that it had become aware of some accuracy issues related to the online beneficiary lookup tool. This tool is available through the COBC secure website and can be used by RREs to query an individual's Medicare enrollment status and receive an immediate response.

CMS stated that it thought it had resolved the issue previously but recently has been presented with examples where it appears that the lookup tool is "out of sync" with actual Medicare enrollment records.

"Revamped" NGHP User Guide and Other Forthcoming Guidance

CMS also announced that the agency is in the process of revamping the user guide to make it more user-friendly. Representatives stated that the revised user guide will be reorganized and may be published in the first quarter of 2012, along with a "quick reference guide" and a "frequently asked questions" document related to the technical aspects of reporting.

CMS also stated that it plans to establish a workers' compensation Medicare set-aside arrangement portal in the future.