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Court Rules That State Bar's Professional Liability Fund Is NOT Subject to MMSEA Reporting

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In the case of ***Oregon State Bar Professional Liability Fund v. United States Department of Health and Human Services & Kathleen Sebelius***, No. 03:10-CV-1392-HZ, 2012 WL 1071127 (D. Oregon, March 29, 2012) the court (Marco Antonio Hernandez, J.) ruled that a legal malpractice policy, which did not provide coverage for bodily or emotional injuries, was *not* an "applicable plan" subject to Medicare's mandatory reporting requirements under the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).[1]

In reaching this decision, the court examined the MMSEA in relation to certain provisions pertaining to Medicare's secondary payer and conditional payment recovery rights under the Medicare Secondary Payer Statute (MSP)[2]. The court found particularly significant the fact that the terms "applicable plan" under the MMSEA and "primary plan" as used in the MSP shared identical definitions. Further, the court noted evidence reflecting that the underlying purpose of the MMSEA's reporting requirements was to help Medicare recuperate conditional payments.

From this evaluation, the court viewed an "applicable plan" as a plan that has primary responsibility for paying for medical services thereby potentially subjecting the plan to the MSP's conditional repayment provisions as a "primary payer."

Turning to the facts, the court found that the legal malpractice policy in this case only covered economic damages, and specifically excluded coverage for bodily or emotional injuries arising from tortious conduct. As such, the court concluded that this plan would *"never have primary responsibility"* for medical services claimed by a Medicare beneficiary and, therefore, would *"never be subject to repayment obligations"* to Medicare under the MSP.[3]

Accordingly, the court ruled that this legal malpractice policy was *"not a liability insurance plan that Congress contemplated when it imposed reporting requirements for primary plans that have a repayment obligation to Medicare"* and thereby found that the plan was *"not an applicable plan subject to reporting requirements mandated by the [MMSEA]."*[4]

This article breaks down this interesting ruling and examines possible implications in terms of MMSEA compliance as follows:

Facts

The *Oregon State Bar Professional Liability Fund* (hereinafter "PLF" or "Oregon State Bar PLF") is a non-profit corporation that provides legal malpractice insurance for all active members of the Oregon Bar covering an attorney's errors and omissions in connection with his/her provision of legal services.[5] This plan does *not* cover claims for bodily or emotional injuries arising from tortious conduct.[6]

In July 2010, the PLF requested a formal opinion from the *United States Department of Health and Human Services* (hereinafter "DHHS") confirming that the PLF was *not* subject to the MMSEA's reporting requirements.

In response, DHHS advised that it considered the MMSEA to apply to the PLF. Specifically, DHHS concluded that the PLF, as a form of liability insurance, was an "applicable plan" under the MMSEA and, therefore, it was required to report thereunder.

After receiving this response, the PLF filed suit against DHHS asserting the

following claims: **(1)** a declaratory judgment that it was *not* an "applicable plan" or Responsible Reporting Entity (RRE) required to report under the MMSEA; **(2)** that DHHS acted *ultra vires* in concluding that it was an RRE; **(3)** that Secretary Sebelius, in her capacity as the Secretary of DHHS, violated the Administrative Procedures Act; and **(4)** that the court had the authority to review Secretary Sebelius' determination.[7]

Both parties filed motions for summary judgment. These motions then came before the United States District Court for Oregon resulting in the ruling discussed herein.

Issue Presented

Whether the legal malpractice insurance policy as provided through the Oregon State Bar PLF is an "applicable plan" subject to the MMSEA's reporting requirements?

Arguments

The PLF argued that it was not an "applicable plan" for MMSEA purposes. Specifically, the PLF argued that since its legal malpractice policy did not cover claims for bodily or emotional injuries[8] it was not a "primary plan" under the MSP *"that would ever be subject to a repayment obligation for conditional payments made by Medicare"*[9] and, therefore, it was not an "applicable plan" subject to the MMSEA's reporting requirements.

DHHS countered that the PLF, as a form of liability insurance, was an "applicable plan" per the definition of this term under the MMSEA and, therefore, had a duty to report there under. Furthermore, DHHS argued that a malpractice claim involving a personal injury case could involve medical expenses paid by Medicare regarding which Medicare could have a reimbursement claim under the MSP.[10]

How Did the Court Rule?

The court ruled that the Oregon State Bar PLF was *not* an "applicable plan" for MMSEA purposes and, therefore, had no reporting obligations under the MMSEA.

The court commenced its analysis by stating that *"[t]he outcome of this case depends on the interpretation of the relevant Medicare statutes."*[11] From the court's view, the "relevant" statutes for its consideration involved specific sections of the MSP and MMSEA as follows:

Court Analyzes the MSP

The court first examined certain MSP provisions pertaining to Medicare's secondary payer status and conditional payment recovery rights. The court's analysis of these provisions ultimately played a significant role in its assessment of the PLF's reporting obligations under the MMSEA.

The court noted that per 42 U.S.C. § 1395y(b)(2)(A)(ii) Medicare is considered the secondary payer and does not pay for medical treatment to the extent that "payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or *liability insurance policy or plan* (including a self insured plan) or under no fault insurance." (Emphasis by the court).

With respect to this section, the MSP states that the term "primary plan" means a "workmen's compensation law or plan, an automobile or *liability insurance policy or plan* (including self-insured plan) or no fault insurance." 42 U.S.C. § 1395y(b)(2)(A) (Emphasis by the court).

As an exception to the general rule set forth under 42 U.S.C. § 1395y(b)(2)(A)(ii), the court noted that the MSP permits Medicare to make payments for medical treatment *"if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly … ."* 42 U.S.C. § 1395y(b)(2)(B)(i). These payments are considered "conditional payments" and are subject to reimbursement under the MSP to the extent that the primary plan demonstrates "responsibility" per 42 U.S.C. § 1395y(b)(2)(B)(ii).

From its review of these statutes, the court concluded that *"[b]ecause [the PLF] offers legal malpractice insurance for attorneys, subparagraph (ii) is the relevant portion of the statute.*[12]

Court Analyzes the MMSEA

The court then focused on the MMSEA by first considering the general intent behind the new reporting requirements. With respect to the MMSEA's objectives, the court found that Congress added the MMSEA to *"improve [Medicare's] ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data[.]"*[13]

Further, the court referenced that the Government Accountability Office (GAO) believed that the MMSEA would assist Medicare to *"identify which payments were made by Medicare that should have been the primary responsibility of another payer."*[14] Accordingly, the court concluded that *[i]t is evident that Congress added the reporting requirement so that [Medicare] could recuperate conditional payments that were made by Medicare."*[15]

By way of requirements, the court noted that under the MMSEA an "applicable plan" was obligated to *"determine whether the claimant is entitled to Medicare benefits and if so, to submit information to [Medicare] for the coordination of benefits."*[16] The court then focused on how the MMSEA defined "applicable plan."

Under the MMSEA, the term "applicable plan" is defined as follows:

> The term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:
>
> (i) *Liability insurance* (including self-insurance).
>
> (ii) No fault insurance.
>
> (iii) Workers' compensation laws or plans. (Emphasis by the court)[17]

Significantly, the court found that the definition of applicable plan "mirrored" the definition of "primary plan" under the MSP in that both terms included *liability insurance* as part of their definitions.[18]

Court Concludes that the PLF Is Not an "Applicable Plan" Subject to MMSEA Reporting. How Did the Court Reach this Decision?

From its analysis of the MSP and MMSEA as above, the court then turned its attention to determining whether or not the PLF was subject to the MMSEA's reporting requirements.

In addressing this core issue, the court started by noting that it was undisputed that the PLF was a type of liability insurance. Further, both parties agreed that the purpose of the MMSEA was *"to help Medicare recover conditional payments that were made when the primary payer was actually responsible for payment."*[19]

Regarding the definition of "applicable plan" under the MMSEA, the court recognized that *liability insurance* was expressly included within the term's definition. However, the court cautioned that inclusion of liability insurance as part of this definition did not necessarily end the inquiry.

Rather, the court explained that the *"[t]he words of the statute must be read in their context and with the view to their place in the overall statutory scheme."*[20] Analyzing the term "applicable plan" from this broader view the court concluded that an "applicable plan" was a plan that has responsibility for paying for medical services which could thereby subject it to the MSP's conditional payment provisions as a "primary payer." The court stated:

> An applicable plan, which has been defined to include liability insurance, must report [under the MMSEA]. But considering the overall statutory scheme, the purpose of the reporting requirement, and the identical definitions of 'applicable plan' and 'primary plan', it is apparent that 'applicable plan' is a plan that has primary responsibility for paying the medical item or service claimed and thus, could be subject to repayment obligations from conditional payments made by Medicare.[21]

From this interpretational perspective, the court zeroed in on whether the PLF at issue could be considered an "applicable plan" required to report under the MMSEA. An important part of the court's focus centered on the

nature and extent of the coverage provided through the PLF.

On this point, the court found it significant that the PLF only covered economic damages stemming from an attorney's provision of legal services, and did *not* cover claims for bodily or emotional injuries arising from tortious conduct. Further, the court noted that the typical malpractice claim is asserted "years after" an attorney has erred with respect to his/her provision of legal services.

Weighing these factors, the court found that *"[i]f the PLF pays a claimant, it is paying for a claim arising from legal malpractice, not health care services."*[22] Accordingly (and significantly), the court concluded that *"[u]nder these circumstances, the PLF will never have primary responsibility for paying items or services claimed by a Medicare beneficiary, and thus will never be subject to repayment obligations to [Medicare]."*[23]

The court then addressed DHHS' argument that a malpractice claim involving a personal injury case could include medical expenses conditionally paid by Medicare.[24] While acknowledging that such payments could be made, the court remained "unconvinced" that the PLF's involvement in this context would ultimately make it an "applicable plan" for several reasons.

First, in these cases the PLF does *not* have primary responsibility to pay for a claimant's medical injuries; rather this responsibility falls to the insurers who insure the parties involved in the underlying incident. Further, the court again noted that the PLF does not cover bodily or emotional injuries.

Second, the court pointed out that there is generally a "significant time lag" from when an individual is injured in an accident to when the PLF ultimately pays out on a malpractice action. Thus, the court reasoned that while Medicare may have made conditional payments in relation to the underlying accident, *"it is highly unlikely that Congress expected reimbursement from legal malpractice carriers. More likely than not, Congress expected the primary plan, i.e., the liability insurer of one or both parties involved in the accident, to reimburse [Medicare] for the conditional payment."*[25]

Based on all these factors, the court ruled that the PLF was not an "applicable plan" required to report under the MMSEA stating as follows:

> The PLF is not a liability insurance plan that Congress contemplated when it imposed reporting requirements for primary plans that have a repayment obligation to Medicare. I find that the PLF is not an applicable plan subject to reporting requirements mandated by the [MMSEA].[26]

Accordingly, the court granted the PLF's motion for summary judgment with respect to its claims related to determining whether it was an "applicable plan" for MMSEA reporting purposes.[27]

Practical Considerations

As the smoke clears from the *Oregon State Bar PLF* case, interesting questions emerge regarding the potential impact this decision could have with respect to MMSEA compliance.

Overall, this case is certainly significant in that it involved a direct legal challenge to a core component of the MMSEA and CMS' reporting directives. This challenge opened the door to judicial scrutiny into the issue of who is subject to report under the MMSEA. In that respect, the court evaluated and balanced key statutory terms and provisions pertaining to the MMSEA *and* the MSP, with respect to their statutory interrelation and larger policy objectives.

In relation to the issues raised, this case would seem to call into focus an interesting (and, for many, a frustrating) aspect of the MMSEA. Specifically, CMS' reporting directives and expectations regarding insurance forms and claims which arguably dance at the periphery of (if not actually outside the bounds of) the MMSEA's underlying objectives. On this point, there is certainly a view in some circles that CMS has taken a conservative approach regarding who must report and the type of claims subject to reporting as part of its implementation of the MMSEA.

These concerns arise most often in the context of claims where injuries are not claimed, not typically part of the underlying action, or where perhaps coverage for any alleged injuries would not be available despite the presences of a colorable personal injury allegation by the claimant. Under CMS' current reporting directives, these claims could still end up being reportable.

The crux of this issue is perhaps best illustrated by Section 11.2.5.1 (p. 59) of CMS' current NGHP User Guide which, in pertinent part, states as follows:

> Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers' compensation where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment *has the effect of releasing medicals*. (Emphasis by CMS).
>
> There are certain, very limited liability situations where a settlement, judgment, award or other payment releases medicals or has the effect of releasing medicals, but the type of alleged incident typically has no associated medical care and the Medicare beneficiary … has not alleged a situation involving medical care or a physical or mental injury.
>
> *This is frequently the situation with a claim for loss of consortium, an errors or omissions liability claim, a directors and officers liability insurance claim, or a claim resulting from a wrongful action related to employment status action is alleged. Current instructions require the RRE to report claim information in these circumstances*. (Emphasis Added).[28]

In certain respects, the nature of the issues raised in the *Oregon State Bar PLF* case place the spotlight on this issue in general, and the above User Guide provision in particular. As discussed above, the court in this case acknowledged that the PLF's legal malpractice policy was a form of liability insurance. However, it declined to find that the PLF was an "applicable plan" for MMSEA reporting purposes since the policy did not provide medical coverage, thereby meaning it could not be considered a "primary payer" under applicable MSP provisions designed to protect Medicare's secondary payer status.

Thus, where does the court's decision in *Oregon State Bar PLF* leave the industry in determining MMSEA compliance obligations in this context? On this question, the court's decision presents interesting considerations on a micro and macro level, both of which, from the author's perspective, require a degree of caution.

On a micro level, it is important to keep in mind that this case involved a legal malpractice policy which specifically excluded medical coverage. This was a key factor in the court's analysis. In this sense, there may be a marked difference in a court's view, from a statutory standpoint and/or a policy perspective, between a situation where the policy at issue does *not* provide coverage for medical versus a scenario where medical coverage for physical or emotional injuries is available or potentially includable, although a claim for such injuries has either not been asserted, or has been asserted but not pursued.

On a macro level, it is unknown whether DHHS will appeal this decision and, if so, whether the appeals court would uphold the district court's ruling. Also, it is important to remember that this court's decision may have limited binding or precedential affect outside the jurisdictional province of the United States District Court for Oregon. In that respect, it is possible that another court could rule differently thereby creating conflicting judicial opinions regarding parties' compliance obligations in this area.[29] It is also possible that another court may decline to even entertain declaratory review on ripeness or other procedural grounds.

For these reasons, proceeding conservatively regarding the significance and application of the *Oregon State Bar PLF* decision may be the prudent course in order to allow these potential contingencies to settle. Nonetheless, and as part of this post-

decision evaluation process, it will be interesting to see if this case now opens the flood gates to similar or other challenges to CMS' implementation of the MMSEA.

In closing, CPSC will continue to monitor any developments regarding the *Oregon State Bar PLF* case and will provide updates as events may warrant.

About the Author

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Endnotes

[1] The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), as it relates to reporting claims to Medicare, is codified at 42 U.S.C. §§ 1395y(b)(7) and (b). Subsection (7) concerns group health plans. Subsection (8) concerns liability insurance (including self-insurance), no-fault insurance and workers' compensation which are commonly referred to as non-Group Health Plans (NGHP). The court's decision in this case dealt with MMSEA compliance under subsection (8) (NGHP). It is noted that the MMSEA is also commonly referred to as "Section 111," "SCHIP," and the "Extension Act." In this article, the author will use MMSEA.

[2] In regard to its discussion of the MSP, the court referenced 42 U.S.C. § 1395y(b)(2)(A)and (B).

[3] *Oregon State Bar Professional Liability Fund v. United States Department of Health and Human Services & Kathleen Sebelius*, No. 03:10-CV-1392-HZ, 2012 WL 1071127, at *5 (D. Oregon, March 29, 2012).

[4] *Id.*

[5] *Id.* at *1.

[6] *Id.* at *5.

[7] As will be noted, with respect to the claims asserted by the PLF, the term "Responsible Reporting Entity (RRE)" is referenced. Under the actual statutory text of the MMSEA, the term "applicable plan" is used to define those entities required to report under the MMSEA. As part of CMS' implementation of the MMSEA, the agency started to use (and continues to use) the term "Responsible Reporting Entity (RRE)" to describe and define those entitles subject to MMSEA's reporting requirements. CMS' current RRE directives are contained in Chapter 7 of its *Non-Group Health (NGHP) User Guide, Version 3.3 (December 16, 2011)*. As the court in this case used the term "applicable plan" in its discussion and analysis, the author likewise utilizes "applicable plan" in the remaining parts of this article in recognition of the court's usage and for the sake of consistency.

[8] In support of this point, the PLF included the following as part of its summary judgment filing:

> The plan specifically excludes coverage for tortious conduct as defined under Oregon law, meaning conduct that results in an injury to person or property:
>
> [GENERAL TORTIOUS CONDUCT EXCLUSIONS]
>
> 16. This plan does not apply to any CLAIM against any COVERED PARTY for:
>
> a. Bodily injury, sickness, disease, or death of any person.
> b. Injury to, loss of, or destruction of any real, personal, or intangible property or loss of use thereof; or
> c. Mental anguish or emotional distress in connection with any CLAIM described under Subsections a or b.
>
> *Plaintiff's Memorandum in Support of Motion for Summary Judgment*, October 21, 2011, at p. 13.

[9] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *4.

[10] *Id.* at *5.

[11] *Id.* at *2.

[12] *Id.*

[13] *Id.* at *3, citing 153 Cong. Rec. S15835 (Dec. 18, 2007) (statement of Senator Charles Grassley).

[14] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *3, citing GAO Testimony to Congress, Medicare Secondary Payer, June 22, 2011.

[15] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *3.

[16] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *3, citing 42 U.S.C. §1395y(b)(8)(A)(i)-(ii).

[17] 42 U.S.C. § 1395y(b)(8)(F); See also, *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *3-4.

[18] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *4.

[19] *Id.*

[20] *Id.*, citing, *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000)(quotation omitted).

[21] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *4.

[22] *Id.* at *5.

[23] *Id.*

[24] On this point, DHHS presented the following example as part of its argument:

> [A]n attorney may be sued for malpractice for failing to file a personal injury lawsuit within the applicable statute of limitations (citation omitted). In that case, under the PLF's plan, there could be a viable claim for damages resulting from the PLF-covered activity at issue (practicing law). The potential damages could include medical bills or costs incurred by the attorney's client that would have been included in the personal injury lawsuit that was not properly filed. The damages that could be awarded through the PLF would account for the difference in the outcome of the personal injury case caused by the failure to timely file the lawsuit (citation omitted). This difference could encompass medical expenses incurred by the client, including those paid or covered by Medicare. *Defendant's Memorandum in Response to Plaintiff's Motion for Summary Judgment and in Support of Defendant's Cross-Motion for Summary Judgment,* November 14, 2011, at p. 4.

Along these same lines, DHHS argued that as part of the PLF's coverage of economic losses the PLF *"could include payment that has the effect of accounting for medical expenses or bills. In such circumstance, it is possible that the PLF could be a 'primary plan.'"* *Id.* at p. 14.

In addition, DHHS made an argument that the PLF was ignoring the fact that under CMS' MMSEA directives reporting is fact and situational specific. In that regard, DDHS argued that CMS' classification of an entity as an RRE does not necessarily mean that the claim must be reported, notwithstanding the fact that the claimant may be a Medicare beneficiary. In that sense, DDHS argued that the PLF was essentially confusing the issue of whether or not reporting is required in a particular instance with the issue of whether or not an entity is an "applicable plan."

On this point, DHHS argued:

> Adopting PLF's interpretation … that 'applicable plans' are the same as 'primary plans,' would not allow [DHHS] to enhance its ability to determine whether or not Medicare is a secondary or primary payer in a given circumstance. Indeed, PLF's interpretation would frustrate the point of Section 111 reporting, because it would prevent [DHHS] from making an 'appropriate determination' under [42 U.S.C. § 1395y(b)(8)(B)(ii)].
>
> The PLF also argues that 'applicable plans' are not entities 'that cover claims where medical damages are not asserted by the claimant.' But the PLF's argument is unmoored from the plain definition of 'applicable plan' in Section 111. Section 111 defines applicable plans to include liability insurance plans (including self-insurance) or arrangements.
>
> Finally, but importantly, whether or not medicals are effectively released in a given case (even if categorized as 'economic loss') is an issue of whether or not the PLF must report under Section 111 in a particular instance, but not an issue of whether or not the PLF is an applicable plan as defined under Section 111. PLF repeatedly confuses the issue of whether or not reporting is required in a particular instance with the issue of whether or not the PLF is an applicable plan under Section 111. While the PLF may have relatively few settlements, judgments, awards or other claims that are reportable, that is separate from whether or not the PLF is an applicable plan. *Id.* at p. 15-16.

[25] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *5. On this point, the PLF as part of its summary judgment filing argued:

> The PLF is simply too far removed from the claimant's medical injuries to be the type of 'primary' insurer that Congress intended to subject to [the MMSEA] and the damages provisions described in that statute. Because the PLF never is a primary plan subject to a conditional repayment obligation, it follows that it is not an 'applicable' subject to a

reporting obligation. *Plaintiff's Memorandum in Support of Motion for Summary Judgment*, October 21, 2011, at p. 22.

[26] *Oregon State Bar Professional Liability Fund,* 2012 WL 1071127, at *5.

[27] As to the other claims filed by the PLF, the court dismissed the PLF's claims that Secretary Sebelius violated the Administrative Procedures Act and acted *ultra vires* in determining that the PLF was subject to the MMSEA finding that these claims were rendered moot by its ruling. The court further ruled that the PLF filed its action in a timely manner. *Id.* at *6.

[28] NGHP User Guide (Version 3.3, December 16, 2011), p. 59.

[29] For example, another court may be willing to consider the argument advanced by DHHS that although a legal malpractice plan (or similar policy) may specifically exclude coverage for physical or mental injuries, it is possible that the potential damages could end up including sums for medical bills or costs. In addition, a court may agree with DHHS' argument confusing the issue of whether or not reporting is required in a particular instance with the issue of whether or not an entity is an "applicable plan." See *supra* note 24.