

Summary of January 15, 2013 Mcare Carriers' Meeting

On January 15, 2013, the Medical Care Availability and Reduction of Error (Mcare) Fund hosted a meeting for those interested in medical malpractice issues in Pennsylvania. The meeting was attended by over 100 representatives of insurers (admitted, exchange, RRG, self-insurer), brokers, hospitals, and provider organizations. The agenda included sufficient time for all to network with counterparts, colleagues, clients, and constituents.

While the published agenda served as a guide to keep the meeting on track, an interactive tone was established early in the meeting. This interactive tone allowed attendees to address their situation-specific concerns with Mcare staff. Key notes from the meeting are described below.

Coverage and Compliance Presentation Highlights

Remittance Advance Form e-216:

Users of Form e-216 listened carefully as Mcare staff explained the most noticeable new feature of the form... the enhanced header.

- If money is due for an e-216, always, always, always include the check # and check amount on the e-216 header.
- Use the enhanced header to track credits. Credits are applied to the account of the carrier. (31 Pa. Code §242.5(b))
- When paying by check, only the check itself is required. Neither a hardcopy 216 nor a cover letter is expected. Unusual situations can be explained in the e-mail.
- When paying by check, always, always, always include the carrier's code on the check and/or check stub. The check number may be hand written.
- If users of the e-216 experience a "circular reference" error, first enable and then run macro. If error continues, insert today's date in the "216 Date" field.
- A request was made for quarterly updates to the e-216.

Noncompliance:

- Lapse noncompliance – 90 or more days has elapsed since the expiration date of the last coverage reported on behalf of the health care provider.
 - Identifying gap noncompliance is an automated process.

- Resolved either through reporting of coverage or by properly completing a Declaration of Compliance form.
- No Coverage – There has been no coverage reported on behalf of the health care provider since the health care provider received their unrestricted medical license.
- Unauthorized – Health care provider had coverage reported on their behalf but an insufficient assessment was remitted, causing the coverage to have a status of “unauthorized”, meaning that it is as if the coverage doesn’t exist.
- Mcare is considering sending an acknowledgement letter to the health care provider when lapse noncompliance is cured.
- Gap noncompliance – Health care provider had coverage reported on his behalf, followed by a period when there was no coverage reported, followed by a period when coverage was reported
 - Identifying gap noncompliance is an automated process.
 - Resolved either through reporting of coverage or by properly completing a Declaration of Compliance form.
 - Mcare is considering sending an acknowledgement letter to the health care provider when Gap noncompliance is cured.
- Tail noncompliance – When a claims-made policy cancels, non-renews or otherwise terminates an extended reporting endorsement (commonly referred to as “tail”) or its substantial equivalent is required.
 - Identifying tail noncompliance issues is currently a manual process.
 - Cannot be resolved through the use of a Declaration of Compliance Form.
 - No exemptions for tail – it is mandatory.
 - Only requirement for length of tail is for as long as there is a reasonable expectation of a claim being filed.
 - Discontinuation of claims-made coverage without obtaining tail or its substantial equivalent must be reported to Mcare by the carrier. (31 Pa. Code §242.7(c))
 - Act 13 requires carriers writing on a claims-made basis to guaranty the availability of continued protection after the claims-made coverage terminates, for so long as there is a reasonable probability of a claim. (40 P.S. §1303.742)

- Declaration of Compliance (DOC) Form
 - Available online.
 - Used to identify exemptions from participation in Mcare and the mandatory insurance requirements of the Commonwealth.
 - Health care provider can log into form using PA medical license number and last five digits of their SSN.
 - If authorized by the health care provider, someone other than the health care provider can complete the form on behalf of the health care provider. Space is provided in the form for that person to identify themselves in the surrogate first name and surrogate last name boxes.
 - Process is all electronic – there is nothing to mail or fax to Mcare.
 - DOC cannot be used to resolve a tail noncompliance issue.
- Reporting Noncompliance to Licensing Agency
 - Mcare has a statutory obligation to report noncompliance to the licensing agency after notifying the health care provider of the noncompliance.
 - Individual health care providers are reported to Department of State, facilities are reported to the Department of Health.
 - Allopathic health care providers certified nurse midwives and podiatrists have license expiration dates of December 31st of every even year.
 - Osteopathic health care providers have license expiration dates of October 31st of every even year
 - Mcare has no statutory authority to take disciplinary action against an health care provider's license.

Payment Methods:

- Currently payment by check is the only method
- In near future, in addition to payment by check, payment options will include:
 - Electronic fund transfer (ACH and wire transfer)
 - Drafting

Tail:

Mcare is researching the issues associated with payment being due to the Fund when a primary tail is written. When the findings of this research are complete and a decision is made, Mcare will communicate the decision.

General Issues:

- Who is a health care provider?
 - A physician, certified nurse midwife, podiatrist, hospital, nursing home, birth center and primary health center. (P.S. §1303.103)
- How is Fund eligibility determined for entities?
 - A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage is required to participate in Mcare. (40 P.S. §1303.744)
- Can bifurcation be eliminated?
 - No, not without a legislative change to the Act. (40 P.S. §1303.712(i))
- Is Mcare participation mandatory for a health care provider performing telemedicine?
 - If a health care provider is practicing telemedicine more than 50% to Pennsylvanians, Mcare participation is mandatory.
- Can Mcare provide carriers the retro date Mcare has in its records?
 - Check with your Coverage Specialist.
- Can Mcare provide carrier with a place where the carrier can check Mcare coverage records for purposes of quoting?
 - Mcare is mindful for Act 13's confidentiality provision, but Mcare will further research this issue.

Claims Presentation Highlights

Section 715 Reminders:

- Mcare's website reminder informs carriers that criticized treatment prior to and after (multiple treatments) 12/31/05 can still qualify for first dollar coverage under this section, if all other aspects of the three prong qualifiers is met.
- Limit of liability for the claim is \$1,000,000 per occurrence, and applies with no aggregate limit, unless previous restrictions by Mcare were imposed.

Future medical damages under Act 13 - Section 509:

- Future medical damages are paid as periodic payments after the proportionate share of counsel fees based upon present value.
- Attorneys' fees and costs are within the present value calculation. O'Conner/Sayler decision took care of this issue; and also consistent with the American Rule – no fee shifting.
- What present value is and how it is funded remains undefined by the courts.
- There is a significant Superior Court case on appeal, which we cannot disclose, that is addressing the calculation of present value.
- The position taken by the defense community is that periodic payments/ stream of benefits based on a person's life expectancy is an annuity. Future medicals are reduced to the cost of the annuity to fund them for life of the plaintiff.
- Discount rate does not apply to this provision – only to calculation of future earnings.
- To our knowledge, no one has asserted the reversionary aspect.
- The annuity cost on life certain may appear to be a windfall to the life company.
- Expert retention and presentation at trial or in settlement is important to counter the plaintiff and reduce these numbers, especially in cases where liability appears to be problematic. Life care planners, economists, life expectancy experts should be retained, unless it is a matter for earlier resolution.

Medicare Secondary Payer Statute Discussion:

- Mcare does not believe we are required to report, but we have elected to do so.
- Reporting once a year after payments are made.
- Need coding information from primary carriers so we may consistently report.

- Playing catch up on 2012 paid claims because we were still registering and in testing phase. We sent letters to carriers requesting the information they reported.
- In the future, provide the reporting information at the time of C-416 report, tender letter, release, and your report to CMS, or other significant points in development of file.
- SMART Act passed and was signed by the President on January 10, 2013. Pertinent areas discussed were:
 - Changes fines and reporting provisions.
 - Changes statute of limitations.
- Mcare also secures a lien guarantee letter from plaintiffs before settlement negotiations and trials. We will direct that a copy be sent to carriers by counsel.

Mcare Alternative Dispute Resolution:

- Promotes resolution of appropriate cases through ADR.
- Promotes early resolution of cases through ADR.
- Where Mcare coverage may be involved, there are specific requirements for notification and structure of ADR matters, and we request suggested cases be brought into discussion with us as soon as recognized.
- Mcare participates in setting of goals for mediation and arbitration.
- Arbitration involves detailed language drafted by Mcare and approved by all defense parties before being presented to the plaintiff.
- Arbitrations are binding and confidential.
- All parties participate in the selection of a mediator/arbitrator. No published list of mediators or arbitrators, but we will suggest those with medical malpractice experience.
- We have experience with over 40 mediators and arbitrators.
- Since 2003, Mcare has participated in approximately 1,080 mediations and arbitrations. In claim year 2012, Mcare participated in 125 ADR processes – 100 were mediations.
- Mcare generated release is required for payment of an arbitration award and must be received by August 31st for payment by December 31st.

Claim Year 2012 Results:

- On December 31st, Mcare paid claims totaling \$195,741,865 representing 404 claims and 267 cases. Total monies paid by parties- carriers, health care providers, entities - on claims involving Mcare were approximately \$600,000,000.
- Mcare payments showed a 12% increase over previous year.
- Five year payment average is \$172,000,000.
- Average case payment was \$733,115. This does not reflect industry results – only Mcare payments.
- Mcare receives approximately 1,700 cases per year. Pending is approximately 7,000 claims.
- Counties with the highest percentage of payments are Philadelphia, Allegheny, Montgomery, and Luzerne.
- 99% of tenders received are \$500,000. We encourage early tender and settlement. In July and August, we received 109 tenders, which we handled effectively, but we would prefer to have tenders earlier when possible.

We reminded carriers that they are welcome to visit and conference on specific claims to discuss developments and potential outcomes. Open, frequent communication is central to our operations and being of service to the medical malpractice community.

* * *