PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D14

PROVIDER
CHI (Catholic Health Initiatives) 1997-2002 Offshore Captive Insurance Groups
Denver, Colorado

Provider Nos: See attached Schedule of Providers

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
November 4, 2004

Cost Reporting Periods Ended -
December 31, 1997 through
December 31, 2002

CASE NOs.: 00-3662G*, 00-3663G, 00-3664G, 02-0983G, 04-0180G, and 04-0443G

*This case was closed and consolidated with 00-3664G

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ISSUE:

Whether the offshore captive investment limitations prescribed in section 2162.2.A.4 of the Provider Reimbursement Manual may properly be applied to disallow all of the premiums paid by the Providers to First Initiatives Insurance, Ltd. for the 1997-2002 cost reporting periods.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare reimbursement is governed by section 42 U.S.C. §1395x(v)(1)(A) of the Social Security Act. In part, the statute states that the "reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." Implementing regulations at 42 C.F.R. §413.9 provide that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services to program beneficiaries. Moreover, the regulation defines necessary and proper costs as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."

[1] The group appeals for fiscal years 1997 through 2000 were heard by the Board on November 4, 2004. Group appeals for fiscal years 2001 and 2002 (Case Nos. 04-0180G and 04-0443G, respectively) were consolidated into the 1997-2000 appeals pursuant to the Parties' joint requests for consolidation dated February 14, 2005.

Section 2162 of Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) provides program guidelines regarding provider incurred costs for malpractice and comprehensive general liability protection, unemployment compensation, workers' compensation, and employee health care insurance. Section 2162.2 of the manual entitled Insurance Purchased From a Limited Purpose Insurance Company, states in part:

> A. Premium Costs.—Some providers, groups of providers, and State hospital associations have established limited purpose insurance companies (often known as captive insurance companies) to insure themselves against malpractice and, in some instances, comprehensive general liability losses as well as unemployment and workers' compensation insurance and employee health care costs. The regular premiums . . . paid to such companies . . . are allowable costs if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions of §2100 . . . .

Moreover, the manual imposes additional requirements where a provider or group of providers is related to the insurer through common ownership or control as defined in HCFA Pub. 15-1 §1000ff. HCFA Pub.15-1 §2162.2.A.4. states, in pertinent part:

> [i]n the case of offshore captives, investments by a related captive insurance company are limited to low risk investments in United States dollars such as bonds and notes issued by the United States Government; debt securities issued by United States corporations or governmental entities within the United States rated in the top two classifications by United States recognized securities rating organizations at the time of investment; .... Additionally, investments may include dividend paying equity securities listed on a United States stock exchange provided that the investment in equity securities does not exceed 10 percent of the company's admitted assets, with the investment in any specific equity issue further limited to 10 percent of the total equity security investment. (Emphasis added).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Catholic Health Initiatives (CHI) is a chain of hospitals (collectively "the Providers"), long-term care facilities, assisted living facilities, and other residential facilities located throughout the United States.[2] During their Medicare cost reporting periods ended in 1997 through 2002, the Providers self-disallowed premiums they paid to First Initiatives Insurance, Ltd. (FIIL), for malpractice, other liability, and workers' compensation insurance. The premium expense was self-disallowed under protest in compliance with applicable manual provisions relative to premium costs paid to related party captive

[2] Providers' Position Paper, Case No. 02-0983G at 1.

insurance companies. FIIL is an offshore captive insurance company wholly owned by CHI, that invested between 40% and 50% of its assets in diversified equity securities contrary to the low risk (10%) limitation imposed by CMS Pub. 15-1 §2162.2.A.4. Mutual of Omaha (Intermediary) is the servicing intermediary for CHI's home office located in Denver, Colorado.[3]

The Providers appealed the subject self-disallowed insurance premiums to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy exceeds $3,000,000.[4]

The Providers were represented by Christopher L. Keough, Esquire, of Vinson & Elkins L.L.P. The Intermediary was represented by Richard Lee of Mutual of Omaha Insurance Company.

PARTIES' CONTENTIONS:

The Intermediary contends that offshore captive insurance companies must comply with the investment restrictions contained in HCFA Pub.15-1 §2162.2.A.4 to prevent unreasonable costs from being incurred by the Medicare program. Offshore captive insurance companies are subject to fewer restrictions and have less reserves than insurers domiciled within the United States and are, therefore, subject to greater risk of insolvency. Testimony elicited at the hearing revealed that liquidations of captive insurers increased by 50% between 2001 and 2002.[5]

The Intermediary also contends that it is common practice for state insurance commissions to restrict equity investments of domestic insurance companies to 10% to 15% of their investment assets. In response to Provider Exhibit P-32, which shows that mutual property and casualty insurance companies allocated between 44.38% to 51.78% of their investment assets to equities over a 5 year period, the Intermediary cites Exhibit I-2 in its Post-Hearing Brief. The Intermediary asserts that the reports in this exhibit are more specific to the instant case in that they narrow the insurance lines of business from "all" to "medical malpractice" and "workers compensation." The table in the exhibit show that the equity allocation percentages for medical malpractice insurers range from 7.23% to 9.37% and for workers compensation insurers from 11.89% to 14.43%.[6] The Intermediary adds that a very conservative U.S. Government bond fund returned an average of 6.975% over the years at issue in this case, 1997-2000 (Exhibit I-16). Notably, this fund would have produced a yield commensurate with the Providers' budgeted portfolio return of 6-7% and would have complied with Medicare program instructions.

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[3] See STIPULATIONS located in Case No. 02-0983G at October 28, 2004.
[4] Providers' Post-Hearing Brief at 15.
[5] Intermediary's Post-Hearing Brief at 10. Transcript (Tr.) at 272.
[6] Intermediary's Post-Hearing Brief at 12 and Exhibit I-2: Brown Brothers Harriman's Insurance Asset Management report dated November 8, 2004 – 5 Year Historical Asset Allocation Table: Page 1 – Medical Malpractice, Page 2 – Workers Compensation.

Finally, the Intermediary disagrees with the Providers' argument that, at a minimum, they should be reimbursed for their actual claims paid and the related administrative expenses pursuant to HCFA Pub. 15-1 §2305, Liquidation of Liabilities. The Intermediary asserts that the provisions of HCFA Pub. 15-1 §2305 are not applicable to non-allowable costs.

The Providers contend that the application of the 10% equity investment restrictions of HCFA Pub.15-1 §2162.2.A.4 is an invalid attempt by CMS to regulate the administration and operation of the Providers' offshore captive insurance company.[7] 42 U.S.C. §1395 states in part:

> [n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the . . . administration or operation of any such institution, agency, or person.

The Providers also contend that they are entitled to be reimbursed for the insurance premiums paid to their offshore captive insurance company pursuant to 42 U.S.C. §1395x(v)(1)(A), Reasonable Cost, and 42 C.F.R. §413.9, Cost Related to Patient Care. The Providers assert that there is no dispute that these costs are necessary and proper as defined in the regulations, and the Intermediary has not shown that the premiums paid to FIIL are substanially out-of-line with insurance premiums paid by other similar providers. Failure of the program to reimburse these costs conflicts with the statute's prohibition against shifting Medicare costs to non-Medicare patients (cross-subsidization).

Moreover, the Providers assert that the Medicare manual's restrictions are "arbitrary and capricious on their face and as applied in this case," and that CMS "has no expertise or competence in the regulation of the business of insurance." They also contend that the manual draws an arbitrary distinction between offshore captives and domestic captives with regard to the allocation of investments by placing no similar limitations on domestically domiciled captives. The Providers further contend that, contrary to Intermediary testimony, many States that regulate the investments of captives do not limit the investment in equities to any fixed percentage. They also maintain that these limitations are inconsistent with other analogous Medicare reasonable cost reimbursement principles governing deferred compensation and pension plans, funded depreciation and paid leave, as Medicare regulations do not limit the allocation of investments in those types of plans.

Finally, the Providers assert that even if the manual's investment restrictions were not inconsistent with all Medicare laws and regulations, at a minimum, the Providers should be reimbursed for the actual losses and any related administrative costs paid by FIIL.

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[7] Provider's Post-Hearing Brief at 19.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the insurance premiums paid by the Providers to First Initiatives Insurance, Ltd. (FIIL) are non-allowable costs for the reporting periods at issue.

It is undisputed that FIIL is an offshore captive insurance company wholly-owned by the Providers. Moreover, it is undisputed that FIIL invested between 40% and 50% of its assets in diversified equity securities contrary to and prohibited by the 10% investment limitations imposed by HCFA Pub.15-1 §2162.2.A.4.

The controversy stems from the Providers' arguments that the investment restrictions are an impermissible attempt by CMS to regulate the business of insurance in violation of 42 U.S.C. §1395, and that they are inconsistent with the program's underlying principle that providers be paid the reasonable costs they incur in furnishing health care services to Medicare beneficiaries.

The Board majority finds as follows:

The investment restrictions of HCFA Pub.15-1 §2162.2.A.4 do not serve to supervise or control the business of insurance that would be prohibited by 42 U.S.C. §1395. The restrictions are not directed in any way to commercial insurance companies or even to captive insurance companies domiciled within the United States. Instead, the restrictions are directed to a narrowly defined body, an allied form of self-insurance that is operated by the Providers through common ownership or control, i.e., a related organization domiciled offshore. Moreover, on its face, 42 U.S.C. §1395 appears especially broad, so much so, that many Medicare reimbursement rules could arguably be judged to exercise some form of supervision or control over the practice of medicine or the administration of an institution, agency or person. Accordingly, the Board majority grants little weight to this argument.

The investment restrictions of HCFA Pub.15-1 §2162.2.A.4 are a valid extension of 42 U.S.C. §1395x(v)(1)(A) and 42 C.F.R. §413.9 and are, therefore, compulsory. 42 U.S.C. §1395x(v)(1)(A) defines reasonable cost for purposes of program reimbursement, and 42 C.F.R §413.9 states that reasonable cost includes all costs that are "necessary and proper" (emphasis added). Because offshore captives are under the control of foreign governments and are not subject to the same level of industry regulations applied to onshore agencies by State insurance commissions, CMS provided guidance and instructions to intermediaries and providers regarding how it would determine the necessary and proper costs with respect to offshore captives set up by related parties. No evidence has been provided that would lead the Board majority to conclude that the investment restrictions of HCFA Pub.15-1 §2162.2A.4 are inappropriate or unreasonable. Rather, the record shows that the 10% limitation/restriction on equity securities is in line with the asset allocations found among domestic insurance companies.[8] The Board

[8] Intermediary's Post Hearing-Brief at Exhibit I-2.

majority finds that CMS was well within its authority and acted appropriately by imposing investment limitations on offshore captives in the determination of reasonable costs. In addition, it is well documented in the record that these provisions were known to the Providers, and that they made a decision to ignore them.

The Providers' argument that the costs incurred for the insurance coverage purchased from the offshore captives are related to patient care and are not substantially out of line with premiums paid by similar institutions is not at issue. (42 C.F.R. §413.9(c)). The Providers were aware of the investment restrictions of HCFA Pub.15-1 §2162.2.A.4 and made an informed and conscious decision to disregard them. The Providers knowingly chose to incur improper costs at the risk of forfeiting Medicare reimbursement in hopes of maximizing investment income. Since the Providers are not in compliance with all applicable laws, regulations and program instructions, the costs in question are not considered allowable for Medicare reimbursement purposes.

Also, there is no merit to the Providers' argument that failure to recognize the subject premium expenses results in program costs being improperly shifted to non-Medicare patients in violation of Medicare's cross-subsidization provision at 42 U.S.C. §1395x(v)(1)(A). Rather, the disallowances are viewed the same as any other cost found to be unallowable, and the cost must be absorbed by the Providers' operations.

The Providers also argue that the investment limitations placed on offshore captives are arbitrary and capricious. In part, the Providers question CMS' experience with insurance underwriting, the distinction drawn between offshore captives and domestic captives that have no restrictions, and the fact that no limitations are placed on other analogous Medicare principles such as those governing deferred compensation plans, pension plans, and funded depreciation accounts. As discussed above, there is an inherent risk associated with offshore captives that justifies the investment restrictions of HCFA Pub.15-1 §2162.2.A.4. Moreover, the record shows that the restrictions themselves are reasonable and in line with investment allocations made by domestic insurance companies. Regarding other analogous reimbursement principles, the Board majority agrees with the Intermediary; funds held in funded depreciation accounts are subject to the protective rules at HCFA Pub.15-1 §226, and pension funds, etc., are subject to the control of other Federal agencies such as the Internal Revenue Service and the U.S. Department of Labor.

Finally, the Providers argue that Medicare should pay its fair share of their actual claims paid and administrative expense if the premium expenses at issue are ultimately found to be unallowable. The Providers assert that when Medicare does not allow reimbursement on an accrual basis, it consistently allows for reimbursement on a cash basis, as, for example, with respect to liabilities that are not timely liquidated (HCFA Pub.15-1 §2305). However, the Board majority finds nothing in §2305 that allows costs found to be non-allowable, as are the costs at issue in the present case, to surreptitiously become allowable. The Board majority also finds that the program is not necessarily obligated to share in a provider's malpractice or other liability losses. HCFA Pub. 15-1 §2162.13 states that "where a provider has no insurance protection for malpractice or

comprehensive general liability in conjunction with malpractice, either in the form of a limited purpose or commercial insurance policy or a self-insurance fund as described in §2162.7, any losses and related expenses incurred are not allowable."

DECISION AND ORDER:

The offshore captive investment limitations at HCFA Pub. 15-1 §2162.2.A.4 were properly applied to disallow all of the premiums paid by the Providers to First Initiatives Insurance, Ltd. for the 1997-2002 cost reporting periods. The Providers' self - disallowance of the premiums is affirmed.

Board Members Participating:

Suzanne Cochran, Esq. (Dissenting)
Dr. Gary B. Blodgett
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West (Dissenting)
Yvette C. Hayes

DATE: January 24, 2007

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Dissenting Opinions of Anjali Mulchandani-West and Suzanne Cochran

We respectfully dissent.

We hold the view that the Intermediary's disallowance of the premiums paid to FIIL should be reversed because it violates the plain meaning of the provisions of controlling Medicare statutes and regulations.

Section 1861(v)(1)(A) of the Social Security Act defines reasonable cost as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs. . . .

The regulations implementing the statutory provision for payment of reasonable cost are codified in 42 C.F.R. §413.9. Section 413.9(a) provides that reasonable cost includes all "necessary and proper costs incurred" in furnishing "services covered under Medicare and related to the care of beneficiaries." The regulation defines "necessary and proper costs" to mean:

> costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

Section 413.9(c)(2) provides further that the principles embodied in this section are:

> . . . intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions . . .

It is undisputed that there are no other regulatory provisions that directly address insurance matters. However, the Provider Reimbursement Manual (PRM) recognizes that liability insurance is a necessary and proper cost related to patient care.

It is only the PRM that imposes additional conditions on reimbursement for costs incurred to obtain liability insurance from a captive. Additionally, it imposes further conditions that apply only to premiums paid to an offshore captive under PRM §2162.A.4. With respect to captives domiciled offshore (but not a captive domiciled onshore), the PRM limits investment in equity securities to no more than 10% of the captive's admitted assets.

The investment allocation limitations in the PRM are not an appropriate application of Medicare statutory reasonable cost principles. The intent of the reasonable cost statute is "to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line." S. Rep. No. 404, 89th Cong., 1st Sess. (1965). In this instance, the PRM requirements of investment limits far exceed the statutory requirements for reasonable costs in that the PRM deprives the Provider of an entire category of expense that is indisputably considered reasonable and proper.

The investment allocation limitations in the PRM are not an appropriate application of Medicare regulatory reasonable cost principles. The regulation establishes as the test for allowability whether costs are "substantially out of line" with those of other providers. The PRM establishes as the test the amount of investment in equity securities. We, therefore, conclude that the PRM provisions limiting investment fail the test of an interpretive rule "'issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.'" Chrysler Corp. v. Brown, 441 U.S. 281, 302, n. 31, 60 L. Ed. 2d 208, 99 S. Ct. 1705 (1979) (quoting Attorney General's Manual on the Administrative Procedure Act 30, n. 3 (1947). As the Secretary recognizes in the Foreword to PRM, it does not have the force and effect of law and is not accorded that weight in the adjudicatory process. The Intermediary relies heavily on Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87 (U.S. 1995) for the principle that the Secretary cannot be expected to address in regulations every detailed and minute reimbursement issue that might arise. Interpretive rules and policy statements are appropriate to give effect to the statutory principles and the background methods embodied in the regulations. While such interpretive rules are exempt from the notice and comment provisions of the Administrative Procedure Act, see 5 U.S.C. § 553(b)(A), they must nevertheless explain existing law and not contradict what the regulations require.

In Guernsey, the PRM provision in issue did not deprive the provider of reimbursement but rather governed the timing and method of calculation for determining reimbursement. In stark contrast to Guernsey, we read the PRM provisions in issue here to be devoid of any link to the standards expressed in the regulations in that there is no test relating to reasonableness of premiums. Nothing in the regulation indicates that a comparison of premiums has any relation to investment choices *unless* it results in premiums that are out of line with other Providers. Even if the premiums were out of line, there is no authority to totally disallow all premium costs.

We conclude, therefore, that the PRM's investment limitation adopts a new position inconsistent with any of the existing regulations[9] and, therefore, effects a substantive change in the regulations.

The evidence in this case illustrates why the rulemaking process is critical to establishing standards such as those involved here. For example, the PRM provides for discriminatory treatment of premiums paid to onshore and offshore captives because it

[9] See Shalala v. Guernsey at 100.

does not limit the allocation of investments by an onshore captive. The CMS witness responsible for the policy on pension costs could not articulate what criteria is appropriate or what was used to establish the policy stated in the manual. She testified that the discriminatory treatment was based on the belief that States' limited the investments of onshore captives but she did not know which States were considered in the formulation of the limitation of offshore captives' investments. Evidence elicited at the hearing demonstrated that the majority of States that regulate captives do not limit investments to a fixed, stated percentage. She did not understand the different risks and pertinent criteria between commercial policies and mutual/captive policies or between different types of risks, e.g. life and health versus property and casualty. The evidence also proved wrong several other assumptions CMS believed supported the disparate treatment of offshore captives. The assumption that investments for offshore captives were more limited because there were no state guaranty funds to protect policyholders was wrong in that guaranty funds were not available to domestic captives either. The assumption that IRS or ERISA would exercise oversight of equity investments for domestic captives was wrong and CMS' witness could not explain why Agency's investment limits in other areas were substantially different from ones imposed on offshore pensions. These are precisely the types of criteria that the notice and comment rulemaking process assure are relevant to the reimbursement principles.

We believe the disallowance of the premiums as well as the related administrative costs violates the statutory proscription against cross subsidization and also violates the regulation at 42 C.F.R. 413.9 in that there is no evidence that the premiums were substantially out of line with those of other providers.[10]

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Anjali Mulchandani-West

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Suzanne Cochran

[10] On the contrary, the evidence showed that the Provider's premiums more likely represented considerable savings to the Medicare program.