

Date: 5/22/26

Virtual Meeting

RECEIVERSHIP LAW (E) WORKING GROUP

Tuesday, May 26, 2026

12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

| | | | |
|---|--------------|---------------------|---------------|
| Kevin Baldwin, Co-Chair | Illinois | Christopher Joyce | Massachusetts |
| Laura Lyon Slaymaker, Co-Chair | Pennsylvania | Tom Mitchell | Michigan |
| Joe Holloway / Jack Hom | California | Shelly Forrest | Missouri |
| Rolf Kaumann | Colorado | Tadd Wegner | Nebraska |
| Jane Callanan | Connecticut | Suzette M Del Valle | Puerto Rico |
| Tim Schoenwalder/Yamile Benitez-Torviso | Florida | Jessica Barta | Texas |
| Kim Cross | Iowa | Sofia Pasarow | Washington |
| Walter Corey | Louisiana | | |

NAIC Support Staff: Jane Koenigsman

AGENDA

1. Hear a Presentation and Discuss Medicare Secondary Payer Attachment A
—*J. Alex Martin (Cantilo and Bennett, LLP), Laura Slaymaker (PA), and Kevin Baldwin (IL)*
2. Discuss Any Other Matters—*Kevin Baldwin (IL)*
3. Adjournment

Medicare Secondary Payer (MSP) Framework and Issues for Insurance Receivers

INTEGRATED GUIDANCE FOR PROPERTY & CASUALTY
AND LIFE & HEALTH INSOLVENCIES

Alex Martin

Partner

Cantilo & Bennett, L.L.P.
ATTORNEYS & COUNSELORS

The Current MSP Environment for Insurance Receivers

- Risk of extreme and long-tail personal liability.
- Inherited responsibility for an insurer's pre-receivership MSP failures.
- Recent court rulings abrogate applicable Centers for Medicare & Medicaid Services (CMS) guidance.
- CMS guidance has not been updated to account for these court rulings.
- CMS has not provided applicable go-forward guidance.
- Little applicable guidance exists otherwise.

Consequences of the Current MSP Environment

- Uncertain reserves;
- Delayed distributions;
- Increased claw back risk;
- Contractor reluctance;
- Hesitancy to close estates;
- Higher administrative costs.

MSP and The Federal Priority Statute (FPS)

The Department of
Justice's (DOJ) position
(last confirmed November
18, 2025)

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“[B]ecause the Medicare Secondary-Payer Statute . . . specifically relates to the business of insurance, the McCarran-Ferguson Act . . . *does not apply* to Medicare claims. Therefore, the Federal Priority Statute . . . *does apply*, and the **MSP claims must be paid before policyholder level claims.**”

-Sharon C. Williams, Esq., DOJ

The FPS (31 USC § 3713)

The FPS provides that, outside of bankruptcy, “[a] claim of the United States Government shall be **paid first**” when a debtor is insolvent, and further provides that “a **representative**” who pays other debts before satisfying Government claims “is **liable to the extent of the payment for unpaid claims of the Government.**”

Traditional FPS Release Agreement

Credit General Insurance
Company, excerpt from
agreement filed with Ohio
receivership court and
available online

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1. Except only for possible federal tax, fraud (including, but not limited to, securities and pension benefit fraud), criminal liabilities, or reimbursement liabilities and penalties arising under 42 U.S.C. § 1395y(b), the United States hereby releases and discharges the Chief Deputy and the estate of Credit General from any and all liability under 31 U.S.C. § 3713(b) in connection with the Credit General liquidation.

FPS Release Application

Excerpt from DOJ
Instructions

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The Affidavit also needs to answer the following questions regarding Medicare:

- 1) Did the insurance company have any policies that included coverage for tort liability?
- 2) Did the insurance company have any policies that included coverage for medical expenses?

If the insurance company had policies that included coverage for either tort liability or medical expenses:

- Please state the procedures followed to determine whether the recipients of payments on those policies were 65 years of age or older, disabled, or otherwise entitled to benefits under the Medicare program.
- Please state the procedures followed by the Liquidator to ascertain if payments made pursuant to those policies related to items or services paid for by the Medicare program.
- If Medicare payments were found, please identify the efforts the Liquidator made to resolve the Medicare claims, and also, identify the procedures the Liquidator followed to report the Medicare claims and the insurance company's payments.

Please state in the Affidavit whether the Liquidator has fully complied with all reporting requirements of 42 U.S.C. § 1395y(b)(7) and (8), and all program instructions issued thereunder (presently found at <http://www.cms.gov/MandatoryInsRep/>). Also, please state whether the Liquidator has reimbursed the United States pursuant to 42 U.S.C. § 1395y(b)(2)(B) for all Medicare payments that were made for items and services on behalf of Medicare beneficiaries whose medical care should have been paid for by the insurance company or whose medical care was, or should have been, paid for pursuant to policies issued by the insurance company.

Reported MSP Collection Activity

Excerpt from 2023 Annual
Report on The Medicare
Secondary Payer (MSP)
Commercial Repayment
Center (CRC)

4.4 Amount Returned to the Medicare Trust Funds from the MSP Commercial Repayment Center in FY 2023

Figure 1: Amount Returned to the Medicare Trust Funds

| Direct Collections | Treasury Collections | Excess Collections Refunded | CMS Administrative Costs* | Amount Returned to Medicare Trust Funds |
|--------------------|----------------------|-----------------------------|---------------------------|---|
| \$253,671,174.86 | + \$47,545,291.19 | - \$40,282,946.54 | - \$41,458,106.16 | = \$219,475,413.35 |

*"CMS Administrative Costs" include contingency fees paid to the CRC as well as certain CMS administrative costs and funds paid to support contractors to facilitate CRC work.

MSP: The Rule

Medicare Is a Secondary Payer

Medicare is secondary to liability insurance, no-fault insurance, workers' compensation, and group health plans.

Medicare may make conditional payments for services when the primary payer has not paid or cannot reasonably be expected to pay promptly.

MSP: The Two Foundational Obligations

The Duty to Report

In general, insurers must report as responsible reporting entities (RREs) when:

1. a payment is about to be made to a Medicare beneficiary for a claim involving or releasing responsibility for medicals (non-group health plan (NGHP) total payment obligation to claimant (TPOC));
2. responsibility for medical treatment is accepted, in whole or in part, going forward for a Medicare beneficiary (NGHP ongoing responsibility for medicals (ORM));
3. coverage or enrollment information is obtained for coordination-of-benefits (COB) purposes (group health plan (GHP)).

Querying CMS for Medicare Beneficiary Status

- Required before NGHP reporting; may also be useful for GHPs.
- Need:
 - first name, last name, date of birth, and gender;
 - social security number, last five digits of same, or Medicare beneficiary identifier.

MSP: The Two Foundational Obligations

The Duty to Reimburse

In general, insures with payment responsibility must reimburse Medicare when:

1. Medicare made conditional payments;
2. Medicare mistakenly paid as primary.

Consequences of Failing to Meet MSP Obligations

- Failure to report - once one year late, civil money penalties (CMPs) up to \$1,000 per day per beneficiary, capped at \$365,000 for NGHPs (not GHPs) per beneficiary.
- Failure to reimburse - potential double damages and interest.
 - Procurement-cost offsets may apply to disputed claims.
- Suit must be filed within:
 - five (5) years from the date reporting was required but not done for CMPs;
 - three (3) years of required reporting for NGHP insurers for recoupment;
 - six (6) years from learning Medicare was or is not primary for GHP insurers for recoupment.

THE EMERGING MSP OPERATIONAL VACUUM

Traditional Assumptions Are Disrupted. [CMS](#) Has Not Filled the Gap.

1 TRADITIONAL MODEL

Guaranty Associations (GAs) Functioned as the Primary MSP Actors



MSP OBLIGATIONS ASSUMED BY GAs

GAs report claims, reimburse Medicare, and manage MSP compliance.



CLEAR OPERATIONAL ROLE

Established CMS guidance and industry practice supported GA responsibility.



RECEIVERS RELY ON GA COMPLIANCE

Receivers focus on estate administration while GAs handle MSP functions.



COORDINATION WITH CMS

CMS interactions, approvals, and reimbursements flow through GAs.



PREDICTABLE FRAMEWORK

Operational expectations were consistent, documented, and widely understood.

2 MODERN CASE LAW

Courts Increasingly Hold GAs Are Not Primary Plans



AZAR AND PROGENY

Courts (9th Cir., 7th Cir., others) hold GAs are not "primary plans" and have no MSP obligations.



DISRUPTION OF LONGSTANDING PRACTICE

The legal foundation for GA reporting and reimbursement obligations is eroding.



LOSS OF OPERATIONAL ASSUMPTIONS

Traditional operational roles, workflows, and reliance on GAs no longer hold.



CMS GUIDANCE LAGS

CMS has not updated guidance or identified who must fulfill MSP obligations going forward.



LEGISLATURE SILENT

No statutory updates to address the shifting legal and operational landscape.

3 UNRESOLVED GAP

An MSP Operational Vacuum Creates Uncertain and Significant Risk



WHO IS THE RESPONSIBLE REPORTING ENTITY (RRE)?

Not the GA. The insurer? The receiver? The estate? Unclear.



WHO MUST REIMBURSE MEDICARE?

If not the GA, who is legally responsible for reimbursement obligations?



EXPOSURE TO ENFORCEMENT & LIABILITY

Civil money penalties, double damages, interest, and potential FPS priority risks.



RECEIVERS LEFT WITHOUT CLARITY OR SAFE HARBOR

Operational paralysis, inconsistent practice, and long-tail personal risk.



NO CLEAR ROADMAP

CMS has not provided a path forward and the gap continues to grow.



THE BOTTOM LINE | The legal landscape has changed. The operational framework has not.

Until CMS provides clear guidance or Congress acts, receivers and estates face an MSP operational vacuum with no clear roadmap—and significant risk.

Current CMS Guidance for NGHPs

Excerpt from Policy
Guidance Chapter Version
8.4 of the NGHP User
Guide (last revised April
13, 2026)

Cantilo & Bennett, L.L.P.
ATTORNEYS & COUNSELORS

Section 111 NGHP User Guide

Chapter 6: Responsible Reporting Entities

6.1.6 Liquidation (settlement, judgment, award, or other payment obligation against the entity in liquidation)

To the extent that settlement, judgment, award, or other payment to or on behalf of the injured party is **funded** from the assets of the entity in liquidation, the entity in liquidation is the RRE.

To the extent that a portion of a settlement, judgment, award, or other payment obligation to or on behalf of the injured party is **funded** by another entity from that other entity's assets (for example, payment by a state guarantee fund), the entity that **makes payment** is the RRE.

To the extent that a payment does not fully satisfy the entity in liquidation's debt to the injured party, the amount reported is the amount paid. Any subsequently approved interim or final payments would be handled in the same manner. Additional payments would be reported as additional TPOC Amounts.

Traditional Receivership MSP Compliance

Credit General Insurance
Company, excerpt from
affidavit filed with Ohio
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available online

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28. In general, except as stated in paragraph 27 above, post-liquidation payments on CGIC covered claims are made by the insurance guaranty associations of the various states in which CGIC was licensed to conduct insurance business. Guaranty associations have the responsibility to report claims payments they make to the extent required by 42 U.S.C. 1395y(b)(8). With regard to those claims which were paid in full by the guaranty associations, neither CGIC nor the Liquidator are Responsible Reporting Entities (“RREs”) required to report pursuant to 42 U.S.C. 1395y(b)(8). For this reason, the Liquidator has not undertaken any procedures to ascertain whether payments made by guaranty associations related to items or services paid for by Medicare. Such procedures are the responsibility of the guaranty associations, as the RRE.

31. The Liquidator will fully comply on behalf of the CGIC Liquidation Estate with all reporting requirements of 42 U.S.C. § 1395y(b)(7) and (8), and all program instructions issued thereunder (presently found at <http://www.cms.gov/MandatoryInsRep/>) by reporting reportable TPOCs at the time the Liquidator makes a payment pursuant to the TPOC Amounts, TPOC Dates (distribution dates) and Reporting Timelines and thresholds set forth in the CMS Alert dated September 30, 2011 or any amendments thereto. The Liquidator’s procedures in the CGIC Liquidation Case are as follows:

MSP Compliance in Receivership

- GHP reporting obligations would seem to track NGHP obligations. A GA providing coverage to a Medicare beneficiary would seem to be the RRE. If the receivership estate is providing coverage, it would seem to be the RRE.
- Reimbursement obligations would seem to track funding responsibility: whoever paid or is responsible for paying the claim or providing the coverage should reimburse Medicare—whether that is the GA or the receivership estate on its own behalf or on behalf of the insurer pre-receivership.

Continued Application of Current CMS Guidance for NGHPs and Traditional Receivership MSP Compliance

- United States v. Rhode Island Insurers' Insolvency Fund - primary plan with reimbursement obligations. Still good law in the First Circuit.
- California Ins. Guarantee Ass'n v. Azar - not a primary plan with reimbursement obligations. CMS later agreed not an applicable plan with reporting obligations.

Application of Azar In the Ninth Circuit, Generally

July 20, 2023 letter from
CMS Responding to
inquiry from Oregon
Insurance Guaranty
Association

Cantilo & Bennett, L.L.P.
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We are responding to your March 14, 2023, letter regarding the Oregon Insurance Guaranty Association (OIGA). You have asked CMS to provide “written confirmation that the OIGA will no longer be subject to conditional payment demands for Section 111...” of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (hereinafter, “Section 111”), codified at 42 U.S.C. § 1395y(b)(7)-(8). Relying on *CIGA v. Azar*, 940 F.3d 1061 (9th Cir. 2019), you assert that OIGA is not a “primary plan” for purposes of the Medicare Secondary Payer (MSP) Act and need not, therefore, submit Section 111 reporting.

Because the Ninth Circuit’s decision in *CIGA v. Azar* is binding on district courts in Oregon, we do not dispute your assertion that OIGA is not a primary plan for purposes of the MSP Act and that Section 111 reporting is not required from OIGA, as the relevant statutory provisions have been interpreted by the Ninth Circuit. Therefore, as of the date of this letter, CMS will no longer consider OIGA to be a primary plan for purposes of the MSP Act.

Our concurrence is based solely on the applicability of *CIGA v. Azar* to jurisdictions in the Ninth Circuit such as Oregon. Thus, this concurrence does not apply to any state outside of the jurisdiction of the Ninth Circuit. Any insurance guaranty association in a state outside of the Ninth Circuit is considered a primary plan for purposes of the MSP Act and is required to comply with Section 111 reporting requirements.

Continued Application of Current CMS Guidance for NGHPs and Traditional Receivership MSP Compliance (Continued)

- Illinois Ins. Guar. Fund v. Becerra – not a primary plan with reimbursement obligations.
- North Carolina Ins. Guar. Ass’n v. United States Dep’t of Health & Hum. Servs. – the court’s preliminary position was that the litigating fund had no reporting obligations but potentially had reimbursement obligations under state law. The case was dismissed without resolution of the issue by the court. According to NCIGF, however, CMS agreed the fund has no obligations.
- According to NCIGF, the Kentucky Insurance Guaranty Association has secured an administrative ruling that it has no MSP obligations.

MSP-Related Issues Encountered

- Federal government claims;
 - Limited detail and follow up;
 - Court rulings holding receivership estate claims filing deadlines and bar dates do not apply.
- Defining scope of MSP obligations;
 - CMS has not meaningfully responded to our inquiries.
- Fulfilling MSP obligations;
 - Incomplete data;
 - Difficulty obtaining data;
 - Inadequate guidance.

Potential Scenario #1 — Post-Closure Demand

- During receivership, neither the guaranty associations nor the receivership estate meet MSP reporting obligations for five (5) Medicare beneficiaries.
- Each of these beneficiaries received \$5,000 in benefits from Medicare that should have been paid by the insurer as primary.
- The receivership closes after \$50 million is distributed to policyholder-level claimants.
- Three years after receivership closure, the federal government demands repayment of at least **\$1.85 million** from the former receiver and estate representatives **personally**.

Potential Scenario #2 — Late-Stage Demand

- During receivership, neither the guaranty associations nor the receivership estate meet MSP reporting obligations for five (5) Medicare beneficiaries.
- Each of these beneficiaries received \$5,000 in benefits from Medicare that should have been paid by the insurer as primary.
- \$100 million is distributed to policyholder-level and other claimants.
- Seven years later when the receivership is approaching closure with limited assets, the federal government demands repayment of at least **\$1.85 million** from the receivership estate and the receiver and estate representatives **personally** for any deficiency and files an associated proof of claim.

Potential Scenario #3 — Liability for Pre- Receivership Conduct

- Six months prior to receivership, an insurer fails to meet its MSP reporting obligations for five (5) Medicare beneficiaries.
- Each of these beneficiaries received \$5,000 in benefits from Medicare that should have been paid by the insurer as primary.
- The receivership closes after funds are distributed to policyholder-level claimants.
- Six months after receivership closure, the federal government demands repayment of at least **\$1.85 million** from the former receiver and estate representatives **personally**.

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Thoughts on Issue Resolution

- Federal legislation;
- State legislation;
- Coordination with guaranty associations and CMS;
- Clear operational protocols and risk management measures;
- Seek court guidance and approvals.

End