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ALERT

# Section 111 Bulletin: Mitigating Medicare Section 111 Reporting Risks - With Civil Money Penalties on the Line, Are You Certain You Are the "Responsible Reporting Entity"?

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Under a long anticipated Centers for Medicare & Medicaid Services (CMS) final rule that took effect in October, casualty insurers face risks of incurring Civil Money Penalties (CMPs) if they fit the Section 111 definition of a Responsible Reporting Entity (RRE) but then fail to timely report to CMS certain payments to Medicare beneficiaries. To mitigate these risks, insurers should take a second look at the reporting requirements CMS has put in place for "Non-Group Health Plans" (NGHPs), that is liability insurers (including professional liability insurers and self-insured entities), no-fault carriers, and workers' compensation laws or plans, through subregulatory agency guidance known as the NGHP User Guide.

Of note, those requirements may face new scrutiny in the wake of the U.S. Supreme Court's June 2024 overturning of the *Chevron* doctrine in *Loper Bright Enterprises v. Raimondo*. CMS has added and tweaked the NGHP User Guide for almost 15 years, but significant ambiguities remain. These ambiguities have real dollar impacts, especially with the arrival of CMPs. For example, insurers should be wary of accepting legal obligations that belong to other NGHPs, whether to facilitate settlement or sidestep difficulties inherent in identifying individual insurer payments in complex settlements. The most immediate risk for such obliging insurers is failing to report to CMS in a *timely manner,* potentially incurring a per day penalty ranging from $250 to $1,000 (before adjustment for inflation). CMS's Final Rule for Section 111 Civil Money Penalties, effective December 11, 2023 (but with an *applicability date* for payment obligations incurred only on or

## Authors

Kathryn Bucher
Partner
202.719.7530
kbucher@wiley.law

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after October 11, 2024), explains that *CMS will not impose penalties on any basis other than reporting timeliness*. It will not penalize RREs for "quality of reporting" or calculate a reporting "error rate," as it proposed to do in the Draft Rule.

That significant change in agency reach is central to our updated analysis of a client's Section 111 obligations and assessment of related legal risks. Using the Final Rule as our analytical springboard, here is one example of why identifying the correct RRE(s) in a litigation scenario is critical to mitigation of both CMPs and possible concurrent liability for return of "conditional payments."

CMS requires RREs to report "total payment obligation to the claimant" (TPOC) settlements. While NGHPs generally accept that that requirement and any related penalties are well-grounded in congressional intent found in the Medicare Secondary Payer statute, agency enforcement of the requirement and any follow-on imposition of CMPs turns on (i) the NGHP User Guide definitions for RRE and TPOC, and (ii) how insurers apply those definitions. CMS agrees. Chapter III of the NGHP User Guide declares in bold letters: "**It is critical that you understand and use CMS' Section 111 definitions when reviewing and implementing Section 111 instructions.**"

With respect to TPOC settlements, CMS historically has appeared disinterested in identifying clearly who or what entity holds the *payment* obligation — whether the insurer or the insured. This ambiguity continues today in the NGHP User Guide. Opinions vary on why this is so, ranging from CMS's relative lack of experience with complex casualty claims settlements (versus its comfort with the arguably simpler administrative process of group health plan payment of insurance claims) to preferring to keep all possible interpretations viable, thereby possibly facilitating the reimbursement of the Medicare program's "conditional payment" of a beneficiary's medical expenses while awaiting a determination of the commercial insurer's obligations as a primary insurer.

One ramification of this obfuscation is that some insurers are overreporting — by reporting the settlement obligations of other entities in addition to their own. We see this most frequently in mass tort or class action scenarios in which insureds have filed coverage claims with multiple insurers that sit within towers of insurance. Given the complexity of these insurance arrangements and the difficulties inherent in timely allocating an individual plaintiff's share of a global settlement among multiple defendants, each perhaps with multiple insurers, the risk of potentially incurring CMPs may influence some insurers to report sooner than later and even include settlement amounts allocated to other NGHPs. Not all these insurers will have an obligation to report.

Here are guiding principles we employ from the NGHP User Guide and discussions with CMS over the past decade when assessing reporting obligations in complex settlements:

- The RRE for a settling defendant is identified at the time that defendant's payment obligation becomes fixed, *not when reporting is required* under CMS's "timeliness of reporting" guidance.

- Ask whether the liability insurer accepted an obligation to pay at the time of settlement or whether its policyholder settled unilaterally with plaintiff(s). A pay-and-chase insured is the RRE, not the insurer that ultimately may accept coverage. There is no reversion back of the reporting obligation.
- Reinsurers have limited reporting obligations, which turn on whether the excess insurer is reimbursing the insured's payment to the injured claimant/plaintiff or paying that claimant directly.
- Further insight into the identity of the RRE and how much each RRE must report comes from the User Guide and CMS's discussion of what the agency calls joint and multiple settlements. Rarely should an RRE report another RRE's share of a policyholder's settlement.

We are aware that some insurers have not forgotten oral comments made by CMS in Section 111 Town Hall calls more than a decade ago. CMS explained then that an insurer could report its policyholder's *total* payment obligation to an individual plaintiff regardless of how many carriers ultimately contributed to the payment. CMS emphasized that carriers should trust CMS to "work it out on the backend," including when demanding that one RRE reimburse CMS for conditional payments that exceed that RRE's coverage obligation to its insured. We believe that direction, if adopted today by CMS, likely would not survive a court challenge, particularly given the issuance of the Supreme Court's *Loper Bright* decision. That legal precedence would encourage a court to review Congress's intent to place Medicare reporting and reimbursement obligations on insurers without giving deference to CMS's interpretation of ambiguous User Guide definitions, particularly where that broad interpretation finds no support in the Medicare Secondary Payer statute and amendments over the past four decades.

Finally, the risk to an insurer in defining its RRE obligation differently than it may have in the past or in choosing to report only its individual payment obligation to its insured, and not its insured's total obligation to the claimant, should be assessed under a careful review of CMS's guidance in the CMP Final Rule. That guidance confirms that CMPs should not fall on an insurer for failing to report an amount that includes another insurer's payment obligation or for not reporting any amount when it had no payment obligation to its policyholder at the time of litigation settlement.

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