

HEALTH FORUM PRESENTATION

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Earlier this year, economists with the Center for Medicare and Medicaid Services (“CMS”) projected that national health care spending increased 5.5% to nearly \$8,160.00 per person in 2009, the third consecutive year of growth in that range. Virtually every stakeholder in health care continues to feel the pinch.

Claims management, particularly management of accident-related health claims, has not been properly investigated as an area of potential cost savings by the federal government. It’s true that industry-wide, these claims accounts for a small percentage of health plans’ total claims volume. According to a recent survey conducted by America’s Health Insurance Plans (AHIP), 14% of claims were pended or delayed in 2006. Of those, health plans reported that 9% were delayed because of coordination of benefits or coverage determination. Some health plans identified possible third-party liability as a reason for pended claims, but not enough to crack the top 10 reasons.

Perhaps the survey didn’t capture the whole story. It is unclear how sharply health plans were able to recognize accident-related claims that may have been the responsibility of an auto insurance, personal injury protection, workers’ compensation policy or some other policy. If accident-related claims went unnoticed, health plans probably processed them like any other claim. Lack of awareness may have accounted for the low percentage of claims reported in the AHIP survey as pended due to possible third-party liability. Industry studies have shown effective subrogation enables health plans to recover 1-2% of total annual paid claims. In 2008 national health expenditures were 2.4 trillion dollars. Effective subrogation could result in a savings of billions of dollars per year. What if health plans don’t know what they don’t know?

Enter subrogation and injury coverage coordination. Both processes are intended to save health plans money – potentially billions of dollars annually – by

recovering paid claims or preventing payment on claims that are someone else's liability. When health plans save money, so, too, do employers and consumers through lower premiums and lower out-of-pocket expenses.

Recovering Claims Through Subrogation

Subrogation requires identification of accident-related claims. This can be a daunting task given the millions of claims plans receive daily. Most claims require several days of processing even without taking time to search for a possible connection to an accident. A 2006 AHIP survey found that four out of five were processed within two weeks of receipt, and 98% within 30 days. State laws and insurance companies' desire to stay competitive have inspired faster turnaround times, which, indeed, have improved in recent years thanks to electronic adjudication. Sometimes lost in the desire to close claims quickly, however, is time allowed to scrutinize them for signs that they are linked to an accident and possibly someone else's financial responsibility. Insurance Journal noted that health plan adjusters' job performance is often measured by how long it takes them to close a claim: "... there is a great pressure to close files and move on to the next claim as quickly as possible."

Not everyone values subrogation. The American Association for Justice formerly the Association of Trial Lawyers of America inaccurately say that it potentially puts members in the middle of insurance companies' bickering, or worse, litigation. A handful of states discourage or prohibit subrogation for fully-insured health plans, even though self-funded welfare benefit plans (ERISA plans) have the contractual right under federal law and governmental sponsored health plans have a statutory right of subrogation. Most importantly, property and casualty insurers, automobile insurers and workers' compensation carriers do not want effective subrogation and injury coordination, because they have been

economically benefiting at the cost of health plans, employers and consumers because the health payors have been paying these accident-related claims.

Sources of Third Party Liability

- Torts (“A civil wrong, other than breach of contract, for which a remedy may be obtained, usually in the form of damages....” In simple terms, a tort is a wrong or harm that one person does to another person (or his or her property).)¹;
- Automobile Accidents;
- Workers’ Compensation;
- Products Liability; and
- Medical Malpractice.

Types of Insurance which should be responsible for accident-related claims

- Auto Insurance
 - Liability
 - Uninsured (“UM”)
 - Underinsured (“UIM”)
 - Personal Injury Protection (“PIP”)/No Fault
 - Medical Payments
- Homeowner's/Renter's Insurance
- Commercial Coverage
- Umbrella & Excess Coverage's
- Workers’ Compensation

A Primer on Subrogation and Reimbursement

¹ Black’s Law Dictionary (8th ed. 2004)

Subrogation

Black's Law Dictionary defines "subrogation" as: "The substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities that would otherwise belong to the debtor"²

With this basic definition of subrogation in mind, *Black's Law Dictionary's* third definition of "subrogation" is perhaps even more germane to the explanation of health payor subrogation. Subrogation, according to the dictionary, is "[t]he principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy."³

Subrogation matters arise any time an individual who is enrolled in a health plan is in an accident or injured by a third party, the health payor pays the medical bills that resulted from the accident, injury or illness. What will oftentimes happen is that the injured (enrolled) party will sue the third party who injured him or her, and a court will determine that the injured party should recover money damages (or the parties will decide out-of-court on a settlement, i.e., an amount of money that both parties agree is owed). Often, part of the money damages the court will award the injured party is to pay for medical bills.

Reimbursement

Reimbursement is a similar principle to subrogation, and the only real difference health plans is the timing of when the health payor has a right to be

² *Id.*

³ *Id.*

paid back the money it paid for medical bills. *Black's Law Dictionary* defines reimbursement as "Repayment."⁴ While the insured certainly should "repay" the applicable health payor, reimbursement in the legal sense is more closely related to the second definition of reimbursement, which is, "Indemnification."

Indemnify means "To reimburse (another) for a loss suffered because of a third party's or one's own act or default."⁵ This may seem like a circular definition, but really to define "reimbursement" as "indemnification" makes good legal sense because of the connotation that is tied to the word "indemnify." To indemnify someone in the legal sense means that you are legally obligated to pay them any money that they needed to pay to a third party because of you.

Just as above, when an individual who is enrolled in said health plan is injured by a third party, and the enrolled individual's medical expenses are paid by the health payor, the health plan should be reimbursed for the money it paid.

At this point, the injured party has been compensated for his medical bills two times: once when the health payor has paid for the medical bills, and then once when the court says the injured party is owed money to cover his medical bills.

What should be done?

1. Legislate the statutory right of subrogation/reimbursement for accident-related claims by a health payor.

⁴ *Id.*

⁵ *Id.*

2. The right of subrogation/reimbursement of accident-related claims should be consistent, regardless if you are an ERISA self-funded welfare benefit plan, Medicare, Medicaid, Federal Employees Health Benefit Plan, government sponsored plan or a fully insured plan.
3. Elimination of the Make-Whole Doctrine⁶ as it applies subrogation/reimbursement of accident-related claims paid for by a health payor.
4. Elimination of the Common-Fund Doctrine⁷ as it applies to subrogation/reimbursement of accident-related claims paid for by a health payor or establishing a statutory fee similar to recoveries on a workers' compensation claim.
5. Require member's legal counsel to provide written notice of a third party claim, that they protect, recover and remit the accident-related claims paid for by a health payor.
6. Permit the health payor to deny or suspend a claim that it identifies as an accident-related claim.
7. Require property, casualty, motor vehicle and workers' compensation insurance carriers to exchange information and coordinate with health payors to ensure that all accident-related claims are properly identified and recovered by said health payor.

⁶ **Make-Whole Doctrine.** *Insurance.* The principle that, unless the insurance policy provides otherwise, an insurer will not receive any of the proceeds from the settlement of a claim, except to the extent that the settlement funds exceed the amount necessary to fully compensate the insured for the loss suffered. (Black's Law Dictionary (8th ed. 2004))

⁷ **Common-Fund Doctrine.** The principle that if a plaintiff or his or her attorney creates, discovers, increases, or preserves a fund to which others also have a claim, then the plaintiff is entitled to recover from the fund the litigation costs and attorney's fees. (Black's Law Dictionary (8th ed. 2004))