HEALTH CARE SUBROGATION 101

PRESENTED AT THE NASP 2000 CONFERENCE

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Presentation Overview

1. Presenter Bio
2. Turning up the Volume on Subrogation
3. Health Care Subrogation Defined
4. Health Care Subrogation Types
5. Types of Health Care Plans
6. Types of Third Party Liability Causing Loss
7. Types of Insurance/Recovery Sources
8. Pursuit and Pay (Pend and Pay)
9. Pay and Pursuit
10. Methods of Identifying Health Care Subrogation Cases
11. Standard Workflow
12. Proper Handling of Healthcare Subrogation Cases
13. Contract Language Design
14. State Regulations
15. Federal Regulations
16. Negotiating Settlements
17. Benchmarking Recoveries
18. Reporting
19. Other Topics ... 
20. Closing
PRESENTER BIO

MICHAEL E. KLUG

Michael E. Klug is the Manager of Meridian's Subrogation and Right of Reimbursement unit. Klug acts as client liaison which includes responsibility for claims system interfacing, coordinating investigations, file management, negotiating settlements, and client reporting of the Meridian subrogation product. Klug is also responsible for the presentation and implementation of subrogation programs, coordinating Meridian's nationwide attorney network and development of Meridian's nationwide library of state and federal laws.

Klug previously worked as a casualty claim adjuster covering the Midwest region and as an agent for a private detective agency specializing in insurance fraud, accident investigations and litigation presentations. Klug has extensive knowledge in evaluating accident liability, determining damages, and negotiating settlements for personal injury subrogation claims.

Klug obtained a Bachelor of Science degree and has completed a Masters of Business Administration, both from Marquette University. He holds the designation of Associate in Claims from the Insurance Institute of America. He is also currently pursuing the Certified Employee Benefit Specialist (CEBS) designation from the International Foundation of Employee Benefit Plans and the Wharton School of the University of Pennsylvania.

Klug is an active member of the Milwaukee Insurance Adjusters Association, Blue Cross and Blue Shield Association and National Other Party Liability Group. Klug is also a member of the National Association of Subrogation Professionals (NASP) and was a speaker at the Inaugural 1999 NASP Conference.

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TURNING UP THE VOLUME ON SUBROGATION

- Identifying More Cases
  - Become More Automated
  - Become Smarter
  - Greater Dedication of Time/Resources

- Increasing Recoveries
  - Create Better contract Language
  - Development of Negotiation Strategy
  - Increased Knowledge of Health Care Subrogation Law/Recovery Sources

- Development of Legal Environment
  - Don't Make Bad Law
  - Increase Professionalism
  - Increase Involvement on Cases
HEALTH CARE SUBROGATION

DEFINED:

Definition: The substitution of one person in the place of another with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies, or securities. (Source: Blacks Law Dictionary, 6th Edition)

Doctrines:

   Equity - The party causing the loss should pay for the loss.
   Unfair Gain - Injured persons should not recover twice and profit from their loss.

TYPES:

Contractual: Legal rights stemming from provision in contract, benefits handbook, summary plan description.

Equitable: States have expressed a public policy against double recovery and unjust-enrichment.

ALTERNATIVES:

Reimbursement

Liens
TYPES OF HEALTH CARE PLANS

- Standard Indemnity insurance
- Health Maintenance Organizations
- Self-Insured Employers (ERISA and Non-ERISA) Associations/Trusts
- Federal Employee Program (FEHBA)
- Medicaid (Title 19)
- High Risk Plans
- Medicare - Part A B and Supplemental
- Physician/Hospital Organizations Reinsurers/MGU's

TYPES OF THIRD PARTY LIABILITY CAUSING LOSS

♦ Motor Vehicle Accidents
♦ Work Related Injuries
♦ Medical Malpractice
♦ Product Liability
♦ Landlord Liability
♦ Slip and Fall/Trip and Fall
♦ Pedestrian
♦ Bicycle
♦ Assaults
♦ Any negligent actions causing injury

TYPES OF INSURANCE / RECOVERY SOURCES

- Automobile Insurance
  - Personal Injury
  - Medical Pay
  - No Fault/PIP
  - Uninsured Motorist
- Underinsured Motorist
- Workers' Compensation Insurance
- Malpractice Insurance
- Landlord Liability insurance
- Homeowners/Renters Insurance
- Umbrella/Excess/Policies
- Commercial Coverage Insurance
- Assets of At Fault Party

PURSUIT AND PAY
(Pend and Pay)

**Pursuit and Pay:** Effort to obtain information through questionnaire or direct call prior to payment.

**Pros:**
- Don't pay unless you get cooperation.
- Obtain Signed Reimbursement Agreement.

**Cons:**
- Information obtained not sufficient.
- Needs additional investigation.
- Customer Service nightmare.
- Huge backlog of pended claims.
- Possible bad faith claims.
- Signed reimbursement agreement not held up in courts.

**PAY AND PURSUIT**

**Pay and Pursuit:** Effort to obtain information through questionnaire or direct call after health plan pays claim according to contracted benefits.

**Pros:**
- Better customer service.
- Claim payers paying claims.
- Higher claims accuracy.
- Dedicated unit focused on third party liability and investigations.

**Cons:**
- Possible uncooperative member after claims paid.
METHODS OF IDENTIFYING HEALTH CARE SUBROGATION CASES

Internal Department Referrals
- Customer Service Representatives
- Claim Payers
- Medical Review/Pre-Authorization
- Managed Care (high dollar losses)

Docket Search

Workers' Compensation Data Match

Automated Audit of Paid Claims
- Most thorough, but not 100%
- Diagnosis/procedure codes
- Questionnaire generation
- Dollar Threshold
- Follow Up Investigation

PROPER HANDLING OF HEALTH CARE SUBROGATION CASES

- Cases are open from one to six years.
- On average, cases settle between two and three years.
- Lots of follow up:
  -- Status Letters
  -- Phone Calls
  -- Check for additional related bills
  -- Negotiate liability percentage
  -- Determine Obstacles
  -- Assess available limits/other coverage
  -- Determine necessity of legal representation
CONTRACT LANGUAGE DESIGN

- Clear and unambiguous language.
- Contract and booklet should be same.
- Granting of rights to subrogate/ reimbursement of medical expenses of plan.
- Obligate member to notify plan, sign documents, cooperate and do nothing to prejudice rights of plan.
- Reimbursement from any recovery source.
- "Value of Service"

ERISA Plans: Pre-emption of State Laws
- First Priority Language
- Expressed Waiver of States, Made Whole Doctrines, Common Fund Doctrines and Anti-subrogation Laws

... Will have first (priority) lien rights upon any and all payments (recovery). Whether by settlement, judgment, mediation or arbitration, that the covered person receives...

... First lien will not be reduced due to the covered person’s negligence or due to any attorney fees...

STATE REGULATIONS

- No Subrogation/Anti-Subrogation States
- Make Whole Doctrines
- Common-Fund Doctrines/Attorney Fee
- Statutes of Limitations
- No-Fault States
- Negligence

FEDERAL REGULATIONS
The terms of a self-funded employee welfare benefit plan which is organized and maintained pursuant to the Employee Retirement Income Security Act of 1974 (ERISA-29 U.S.C. sec. 1001, et seq.) preempt those state laws which govern the terms and conditions of other employee benefit plans. 29 U.S.C. sec. 1144(a).

NEGOTIATING SETTLEMENTS

- Determine liability/negligence.
- Know applicable laws/legal doctrines.
- Know your plan language.
- Make them fight for reduction/waiver.
- Request Documentation:
  -- Judgments/Appeals/Awards
  -- Policy Limits Declaration Page
  -- Independent Medical Exams
  -- Policy Language
  -- Verification of other coverage/assets
  -- Reason for reduction/waiver
- Have multiple levels of authority.
- Avoid path of least resistance
  -- Don't take first offer
  -- Increase demand over “Splitting the Difference”
- Reserve rights against other parties/policies.

BENCHMARKING RECOVERIES

Will vary based on product mix, demographics, applicable Federal/State laws, claim paying process and case identification process.

Relevant to Paid Claims: .25% to .75% range
Relevant to Covered Lives (includes dependents): $4 to $10 per life range

Recovery Percentages:
- With full waivers and recoveries: 45% - 65%
- With recovered cases: Only 60% - 80%

REPORTING HEALTH CARE SUBROGATION

- Claims identified for potential
- Diagnosis code/dollar value/referral source

- Cases identified for liability
  - Date of occurrence/accident type

- Investigation status/backlog
  - Pending date/dollar value

- Open cases with actual liability
  - Member information/date of loss/accident type/suit status/file balance

- Recovered Cases
  - Member information/date of loss/accident type/file balance/recovery information

- Cases should be tracked by
  - File handler/state/client/ERISA

OTHER TOPICS

- Joinder/intervention to Litigated Cases
- UM/UIM reducing clauses
- Future medical claims
- Capitation payment and value of service
- Collateral source rules
- Fair Debt Collection Act
- Releases
- Outsourcing
- Use of Attorneys
- Subrogation Technology
CLOSING

- Maintain the momentum
- Create greater emphasis on education needs for Health Care Subrogation
- Network and share information
- Develop industry wide practices
- Increase Subrogation through:
  -- Finding more cases
  -- Maximizing Recoveries
Benchmarking or creating a standard for healthcare subrogation recoveries involves much more than comparing the amounts recovered by two different organizations. The first and most important step is to consider the two organizations themselves. Then, an analysis can be made of the many variables that affect recoveries – everything from the claims payment process to applicable state and federal laws. After accounting for these factors, reasonable recovery comparisons can be calculated and better judgements can be made of why the recoveries may be different for similar sized populations. What factors may influence an organization’s healthcare subrogation recoveries? For healthcare subrogation it is very important to determine the following:

**Claims Payment Process** (pursuit and pay versus pay and pursuit, coordination of benefit efforts, managed care, risk sharing)

**Demographics** (city, rural, age of population, etc.)

**Product Mix** (ERISA, Federal Programs, Title 19, HMO, Indemnity, Medicare Supplement, etc.)

**Case Identification Process** (automated using diagnosis criteria, internal department referrals)

**State & Federal Laws** (no-fault, no subrogation, good state law, federal pre-emptive status, etc.)

The **Claims Payment Process** is at the core of how organizations may differ in healthcare subrogation recoveries. Simply put, if an organization pays out less, it will recover less. Organizations can pay fewer dollars on claims by (a) having more exclusions in coverage (b) establishing managed care programs (c) training providers to submit bills first to workers’ compensation, medical pay, or no-fault carriers (d) using “pursuit and pay” methodology to identify and pend subrogation related claims or (e) sharing risk by allowing providers to pursue recovery for liability/industrial injuries. For example, a managed care HMO is a no-fault state will pay less than a self-insured ERISA plan with generous benefit coverage in a state without no-fault. Subrogation recoveries are directly affected by claim payments. Fewer claims payments equal fewer recoveries.

**Demographics** will also play a large role in determining healthcare subrogation recoveries. A population in a metropolitan area will generate more cases of third-party liability for subrogation and workers’ compensation cases than an equal population in a rural area. This is largely due to a greater “claim mentality” and a larger concentration of plaintiff attorneys in a metropolitan area than in a rural setting. The age of an insured population will also affect recoveries. An older population will produce fewer liability and workers’ compensation recoveries than a younger population. Knowing the demographics of a population, both location and age will assist in comparing organizations and forecasting appropriate recoveries.
The Product Mix of a payer will also affect healthcare subrogation recoveries. These programs may include self-funded ERISA Plans, the Federal Employee Program, Title 19-Medicaid, Standard Indemnity Insurance, Health Maintenance Organizations, Medicare, Medicare Supplemental, Temporary Insurance, Single Policyholders, Small/Large Employer Group Plans and other benefit packages. Each of these insurance program types will affect subrogation recoveries based on a multitude of variables that include, but are not limited to preemption of anti-subrogation laws, statutory recovery rights, large versus small benefit coverage’s, subrogation recovery language, and claims paying processes. The product mix with more state pre-emptive status, greater statutory rights, larger benefits coverage, and better recovery language will provide greater subrogation recoveries.

The Case Identification Process will directly affect recoveries. Obviously, the more subrogation cases identified and opened for potential recovery, the more recoveries will result. Use of an automated identification process reviewing claims diagnosis and procedure codes with traumatic, industrial or medical association to potential third-party liability and workers’ compensation cases is a necessary tool to find the most cases. This is much better than attempts at manual identification by already too busy customer service, claims, and medical review staffs. However, a program that combines an automated process with in-house staff awareness of the importance of subrogation savings is the best program possible to maximize case identification. This pairing will ultimately lead to maximization of subrogation recoveries.

Finally, the Applicable and Federal Laws in an organization’s jurisdiction will directly affect the ability to pursue, make recoveries and avoid sharing in costs on potential subrogation cases. State laws that will affect recoveries include, but are no limited to: No Subrogation/Anti-Subrogation laws, Made-Whole Doctrines, Common Fund Attorney Fees Doctrines, Statue of Limitations, No-Fault Laws, Coordination with Medical Pay Laws, Negligence Defense, and Passenger Guest Statues. Many self-funded ERISA and federally regulated insurance welfare benefit programs may pre-empt state mandates. However, federal jurisdictions are taking an active role in limiting some pre-emptive abilities if the plan subrogation language is quiet or passive to its pre-emptive rights. It is important to be aware of all state and federal guidelines affecting healthcare subrogation to properly design subrogation language best suited for the type of program and encompassing laws that impact subrogation recoveries.

Even with the above variables outlines, recovery range criteria can be used to forecast and compare recovery programs. The first, Recoveries TO Paid Claims, with a representative mix of variables, may range from .25% to .75% of annual paid claims recovered through a subrogation program. A small group with some catastrophic subrogation claims may see a recovery much higher, but these scenarios are the exception versus the rule. In the same context, occasionally a couple large losses that occur instate with poor subrogation law or with no available coverage can bring a recovery percentage below the norm. If large losses occur in states with good subrogation law and under a wide umbrella policy, the recovery percent may be above
the norm. The second recovery range comparison criteria, Recoveries TO Insured Lives, may range from $3 to $10 per lie per year depending on the variables involved.

Remember that these are general ranges and various unique uncertainties will play a large role in actual recovery results. Stepping back and evaluating the above factors will provide a greater ability to forecast and compare healthcare subrogation recoveries.
JOINDER OF THE SUBROGATED CARRIER

SCENARIO: You have the right of subrogation for medical benefits. The tortfeasor’s insurance carrier has already issued a letter to you indicating your interest will be protected. Despite the fact you have a letter of protection, a court order arrives commanding your company to join an ongoing suite, or be forever barred to assert you claim.

In the above situations, just when the subrogation analyst believes he or she has taken all necessary steps towards ensuring a recovery, he or she finds the insurance company being ordered to litigation. "How can the court order us to join the suit when we already have protected our claim" is a question often posed to subrogation counsel.

Most states have civil rules or statutes that may compel an insurance company that has the right of subrogation to join an existing lawsuit - regardless of the fact that an arbitration agreement exists, a letter of protection has been issued or the insured’s insurance contract requires reimbursement. Ignoring a court order to join action is a bad idea - and it may result in losing your subrogated right.

WHY ARE SUBROGATED CARRIERS BEING ORDERED TO JOIN

Orders to join an ongoing suit are usually the result of a motion filed by an insured’s personal attorney who either believes (1) that the insurance company should assist in establishing a recovery, or (2) the insured’s attorney sees the order as a way to leverage his client’s insurance company to lower a subrogated lien. Indeed, one recent seminar and publication by a plaintiff’s bar outlined the joinder tactic as a way to settle a case where a substantial subrogation lien exists.

Orders to join are often filed by defense attorneys who believe there is a tactical advantage to having the jury know that an insurance company paid the plaintiff’s medical bills or damages. Others have cited the concern of a "double liability" in that their clients can lose at trial and then face either intercompany arbitration or a separate suit filed by the subrogated carrier.

WHAT TO DO IF YOUR COMPANY RECEIVES A JOINDER ORDER

Most importantly, never ignore it. Joinder orders almost always have strict time limitations. Even if your file has already been assigned to subrogation counsel, immediately make counsel aware that you have received a joinder order.

**Excerpt from article in "Ohio Subro Meter" by the law firm of Vozar, Roberts, and Matejczyk**