ObamaCare may mean Healthcare Subrogation goes “Back to the Future”

By Daran Kiefer

Great Scott! Healthcare subrogation may actually be going back in time to what it was before ERISA. As we are all aware, the future of healthcare in the United States is at a crossroads. The traditional model of employer-sponsored health plans may be coming to an end. With the implementation of Affordable Care Act (ACA) or ObamaCare, we are on the precipice of a major shift in the way we obtain healthcare. Whether you support or oppose this change in the healthcare delivery system, the subrogation industry is about to see seismic changes in the way we approach healthcare subrogation recovery efforts. This article will look at where we have been and where potentially we are headed.

The Past:

Prior to the enactment of the Employee Retirement Income Security Act of 1974, commonly called ERISA, healthcare subrogation was governed by the various state laws and case decisions. As with the property and casualty insurance industry, healthcare subrogation was subject to the patchwork of various state laws and case decisions. Healthcare plans were subject to decisions on issues of made whole and common fund based upon the state where the person lived or where the accident may have occurred. Also, subrogation professionals needed to understand the tort laws of each state to determine if they could recover or not. Such recovery efforts often raise concern of exposure to “bad faith” litigation as to the recovery.

The Present:

This varied framework of regulation is what prompted Congress in 1974 to enact ERISA. ERISA governs employer-sponsored health plans. Generally speaking, all health plans offered through an employer are covered by ERISA. The major exceptions are city, state and municipal workers such as school teachers and clerks in the county offices and churches. ERISA was enacted as a way for health plans to be applied consistently across the U.S. so that GM employees in Michigan would get the same benefits as GM employees in Texas.

ERISA achieves this uniformity through explicit statutory preemption of state laws which “relate to” health coverage for both insured and self-funded plans. See 29 U.S.C. §1144(a) ERISA does provide for some state laws to be “saved” from preemption if they regulate insurance, banking or securities. See 29 U.S. C. §1144(b)(2)(A) But self-funded ERISA plans enjoy total preemption of all state laws, even those which regulate insurance. See 29 U.S. C. § 1144(b)(2)(B). If your practice involves healthcare
subrogation, you understand the “preemption”, “savings” and “deemer” clauses impact on subrogation rights.

Under ERISA section 1144, subrogation rights no longer were determined by the fifty states and their various case decisions. Instead, healthcare subrogation waved the banner of ERISA preemption of state rules on “made whole” and other limitations on recovery. The ERISA uniformity provided a way for healthcare subrogation to avoid anti-subrogation rules and decisions in many states.

But the ERISA preemption did not come without its own share of headaches. The healthcare industry had to fight to ensure that ERISA rights could be governed by the terms of the plan. The Supreme Court battles from Great West Life & Annuity v. Knudson, 534 U.S. 204 (2002) to Sereboff v. Mid Atlantic Medical Serv. Inc., 547 U.S. 356 (2006) to finally U.S. Airways, Inc. v. McCutchen, 133 S. Ct. 1537 (2013) required the industry to fight under federal law to allow the healthcare plan provisions to be enforced as drafted, providing full recovery and subrogation rights. Through theses struggles, ERISA healthcare subrogation has arrived to the point where plans can provide for full recovery, eliminating “made whole” and “common fund”

ERISA preemption also has spared the healthcare subrogation professional from concern over extra-contractual liability. The Supreme Court took care of such concerns in the case of Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). In its ruling, the high court held that state claims of “bad faith” and damages were preempted by ERISA. Thus, healthcare subrogation professionals are protected from such extra-contractual risks found under many state laws. Currently, life is good for healthcare subrogation under the federal ERISA framework.

The Future

The ACA or ObamaCare legislation does not directly address subrogation rights but its change in the healthcare delivery and federal regulatory scheme could take subrogation rights back to those prior to ERISA. The ACA provides for coverage for Americans either through expanded Medicaid or by purchase of an “individual” policy through exchanges. Medicaid expansion means more subrogation may be controlled by state statutes created to implement this coverage. All of us are familiar with the limits on Medicaid recovery as affirmed by the Supreme Court in Arkansas Dept. of Health and Human Serv. v. Ahlborn, 547 U.S. 268 (2006) If more individuals are covered by Medicaid, subrogation rights may then be restricted under case law and statutes.

The bigger issue is what happens to those people who don’t qualify for Medicaid and who no longer are covered by an employer-sponsored plan. Such folks will be purchasing insurance through one of the various federal exchanges. When they do this, the healthcare coverage is no longer provided by an employer and essentially becomes an individual policy. This presents three very real issues for the healthcare subrogation community: 1. What law will govern the policies and subrogation rights? 2. Can state laws of bad faith apply? and 3. Will the federal government regulate the “subrogation” provision?
The ACA does not provide for explicit preemption as found in §1144 of the ERISA statute. The only language related to this in the ACA states that “nothing in this title shall be construed to preempt any State Law that does not prevent application of the provisions of this title.” See 42 U.S.C.§18041(d). Unlike the ERISA statute, the ACA doesn’t preempt all laws but only those that prevent its application. The question for subrogation professionals going forward is, “does state law of ‘made whole’ prevent application of the ACA?” The answer to this question is crucial. It may be helpful to consider a factual scenario to illustrate what may happen under the ACA’s less expansive “preemption” statute.

Let’s look at two individuals: one individual covered by an ACA exchange plan and a second individual covered by a self-funded ERISA plan. Both parties live in and were injured in the state of Arkansas. Both injured parties can only recover policy limits of $50,000.00 for an accident. Both plans have paid medical bills totaling $100,000.00 for accident-related treatment. Both health policies contain subrogation and reimbursement rights to recovery whether or not the individual is “made whole”. Clearly, neither individual can be made-whole by this recovery. Is there a difference in the subrogation and/or reimbursement rights between the two coverages?

Under ERISA “preemption,” the health plan would not be subject to the Arkansas “made-whole” case decisions. A self-funded ERISA plan can seek reimbursement and subrogation to the full $50,000.00 tort limits if they chose to enforce it. Under §1144(b)(2)(B), self-funded plans are not covered by any state laws including those that regulate insurance. This self-funded ERISA plan can enforce its first right of recovery to all of the settlement funds.

In contrast, the individual policy provided under the ACA may not fare so well. Does the “made whole” case law doctrine prevent “application of the provisions” of Obamacare? Application of the ACA statute is not prevented when an injured party claims “made whole.” In fact, the Arkansas case law regarding “made whole” does not conflict with any provision of the ACA. If there is no conflict, then state law would not be preempted. Thus, the ACA plan would not be able to recover unless and until the injured Arkansas resident is “made whole”.

The ACA limited preemption provision may signal a return to the pre-ERISA days of subrogation rights. Under 42 U.S.C.§18041(d), Obamacare only preempts state laws which prevent enforcement of the actual statute. Courts are not going to find any statutory provision in the two thousand plus pages of the ACA which may be prevented if an injured party is to be “made whole”. The ACA preemption does not extend to the terms of the insurance plan which may call for full reimbursement as found under ERISA. This difference is key in that healthcare subrogation may be returning to the control of the fifty states and their various laws.

The second big impact of ACA covered individuals is that they are no longer governed by ERISA and its case law. A person who purchases coverage on an exchange does not get their coverage through an employer. For subrogation rights, you no longer can rely on McCutchen which allows a plan to contract away “made whole” and other common law doctrines. Also, the loss of ERISA means healthcare subrogation decisions are subject to litigation for “bad faith”. Without ERISA protection, ACA health plans have to worry about extra-contractual suits for damages. Any mistakes a
subrogation professional makes when pursuing subrogation for an ACA plan may mean your company or your client are subject to litigation for damages in excess of what was actually paid. The property and casualty industry knows all too well how costly and time-consuming such litigation can be. If you have a subrogation claim under an ACA plan, you may want to take extra care in how you respond or attempt to settle the matter.

The third potential impact is what regulations are promulgated by the Department of Labor under the ACA. Will the Secretary of Health and Human Services mandate “subrogation” and “reimbursement” language which provides for the injured party to be “made whole” or allows a “common fund” reduction for attorney fees? The actual language of the ACA does not directly address subrogation rights. But this does not mean that the federal government may not attempt to regulate such obligations hoisted upon participants in ACA exchange plans.

The ACA does allows the Secretary to determine the “essential health benefits package” with respect to any health plan in the areas of providing for essential benefits, cost-sharing and coverage level descriptions. See 42 U.S.C. §18022(a) Specifically, this section allows the Secretary to determine limits of “cost-sharing” which includes “(i) deductibles, coinsurance, copayments or similar charge; and (ii) any other expenditure required of an insured individual which is a qualified medical expense” See 42 U.S. C. §18022(c)(3)(a) The question is, does this give the Secretary the right and authority to limit or restrict cost sharing obligations from accident recoveries? Does the amount due through subrogation and reimbursement qualify as a “similar charge” or “other expenditure” such that the Secretary can restrict or regulate it? These are still open questions which may be primed for the right case to test the limits of subrogation rights under the ACA.

As we journey into the unknown future of subrogation for ACA exchange plans, we may be looking back to how healthcare subrogation was handled prior to ERISA. These individual ACA plans may require healthcare subrogation professionals to learn the ins and outs of subrogation rights in all the states. Healthcare subrogation professionals must make sure they act prudently when dealing with ACA plans to avoid allegations of “bad faith”. Finally, the industry is going to have to wait and see if the federal government tries to restrict, limit or rewrite subrogation provisions under the cost-sharing regulations of the ACA. Subrogation for ACA plans really may be a trip back in time which may cost the industry recovery dollars. Wait and see!