SUBROGATION AND COORDINATION OF BENEFITS

“Great Programs For The 1950s That Have Never Been Properly Updated And Thus Are Driving Health Plans And Everyone Else Crazy”

By Alan Bloom

Note: The contents of this presentation represent the views and opinions of every rational person who had had to deal with these topics.

Coordination of benefits (“COB”) involves several overlapping insurance policies working together to avoid duplication of benefits.

Subrogation involves an insurer providing benefits and then stepping into the shoes of the insured to recover from a liable third party the cost of the benefits given to the insured.

Health insurance will be discussed although these doctrines have some applicability to other types of insurance.

1. Every insurance law course begins with the question: What is the difference between insurance and gambling?
2. Insurance should only reimburse losses under experiences so unpleasant that no one who collects should feel like a winner.
3. Some people have multiple insurance coverages so they could come out ahead if all insurance paid for the same occurrence. (two jobs with insurance; both spouses working jobs with insurance).
4. Some people injured in accidents have insurance that covers their losses and they also collect “reimbursement” for medical bills from the tortfeasor.
5. As a public policy issue, allowing people to make a “profit” on bills for health services gives an incentive to overuse services.

In the 1950s most insurance was indemnity. The patient selects a provider, pays the bill, and submits a claim to insurance.

1. Insurance carriers came out with a policy in which one carrier paid the bill initially, with a second paying the balance. At a time of limited coverage, one policy usually didn’t cover everything.
2. Since insureds could usually go to any provider, both coverages paid something.
3. Carriers began to write policies in which they were always the last payor so consumers often found nobody would pay first and there were great delays in payment.
4. If there was a tortfeasor, carriers would often wait until the tort case was resolved (often many years) before they would pay anything.
5. State regulators and the NAIC came in with uniform orders of benefits and payment requirements for tort actions.
6. If there was a responsible tortfeasor involved, the insurance carrier paid and then was to be reimbursed. However, rarely is fault 100% on either side (so any recovery is reduced), accidents result in many expenses (loss of income, uninsured health matters such as dental and custodial care), and most cases end in settlements. Biggest issue: there is limited recovery since most tortfeasors are uninsured or underinsured. How does the limited money get distributed?

Managed care complicated matters

1. What if the consumer had primary coverage with a managed care company, but chose to go outside the managed care network for care and then billed the secondary indemnity carrier?
2. What if the lawyer for a managed care consumer involved in an accident sent them to “special” doctors outside the network and the case fell apart? Did the managed care plan have to pay the “special” doctors?
3. What if the primary carrier had a discount with a provider, could the provider bill the secondary carrier for the rest of the bill (the amount discounted)?
4. Some carriers excluded coverage for a spouse if that spouse had primary coverage through a managed care plan and voluntarily chose not to use the managed care network.
5. Then there was the benefit bank. What the secondary carrier “saved,” was credited to the enrollee for certain benefits neither carrier covered. In practice, this created confusion.
6. In tortfeasor liability, how is the health plan reimbursed for capitation payments. When risk is delegated, what are the mechanics to “spread” the recovered money?
7. How are necessary billings and records obtained to support a lien with so many parties involved (health plan, doctor, hospital, etc.)?

Now the government sees COB and subrogation as ways to cut expenses by shifting costs to others.

1. The Medicare Secondary Payor Program and new guidelines for reporting settlements/litigation results in Medicare.
2. Employer data bank.
4. Contractors are now involved.
5. It is unclear how much liens in subrogation can/should be reduced.
6. Can an MA plan step into the shoes of CMS when the Medicare recipient is in such a plan?

Enterprise Risk Management Dangers

1. Health plans/payors -- Complex government reporting rules and potential liability to reimburse government programs. STAFF NEEDS TOP UNDERSTAND THE RULES.
2. Employers – Complex reporting and responding to government/contractor inquiries or employer could be stuck with liability. HEALTH BENEFITS EMPLOYEES NEED A DEEP SOPHISTICATION.

3. Lawyers and non-health insurers – Government requires liens be reported and paid. KNOW THE RULES OR SUFFER LOSSES.