Subrogation and coordination of benefits: how to improve your health plan document

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Companies sponsoring group health plans are facing ever-increasing costs due to spiraling health care expenses. Popular cost-containment strategies include wellness plans, disease management and consumer directed plans. One little used strategy is to recover dollars which are owed to the plan, but not paid. Many health plans do not actively audit payments made and do not follow-up on possible third-party recovery options. To recover these dollars, companies should become more active in pursuing subrogation and coordination of benefits opportunities.

Fortunately for group health plans, the courts and states are widening the opportunities for plans to catch these health dollars. This article discusses the current nature of subrogation and coordination of benefits, the rights of group health plans to recover health care dollars, and the changing landscape in this area and some suggestions for plan drafting to assist plans in recovery of health care dollars.

A. ERISA Preemption Dictates Subrogation and Coordination of Benefits Effort by Group Health Plans

ERISA provides group health plans the right to recover funds through reimbursement and subrogation. This right allows the plan to receive "appropriate equitable relief" to enforce the terms of the plan. In *Great West Life and Annuity Ins Co., v. Knudson*, the Supreme Court ruled that "equitable relief" did not include the plan suing the participant for monetary damages nor for restitution where the funds recovered were not in the participant's possession. The Court's decision led to frustration and confusion with respect to attempting recovery of such third-party amounts due where the ability to recover was unclear. However, based upon current law, plans should be actively drafting and executing provisions to recover such funds.

B. Subrogation

Any sponsor of a group health plan should be identifying and investigating medical claims paid that indicate subrogation potential. Most companies contract this duty to their third party administrator, however a sponsoring entity must be certain that it has asked for this service and that the TPA is providing such a service. The recent Supreme Court decision in *Sereboff v. Mid-Atlantic Medical Services* has reawakened interest in subrogation opportunities and reinforces the importance of proper plan drafting.

Every health plan document should be reviewed to determine whether any of these doctrines would apply reducing or preventing the recovery of funds paid to claimants by third parties. Every Plan should contain the following provisions:

- Explicitly identify the funds that shall be recovered (e.g. from third-party tortfeasors)
- Identify the portion of the funds that will be recovered (i.e. the amount equal to costs paid to participant by the plan)
- Provide that the plan attaches an equitable lien to the funds recovered

- Provide that the plan imposes a constructive trust on any proceeds recovered
- Provide that the plan shall not recognize the Made Whole Doctrine or the Full Compensation doctrine
- Explicitly outlaw the Common Fund Doctrine and state that any attorneys' fees are paid outside of the recovered fund
- Provide an allocation scheme allowing the plan first priority for recovering proceeds received from third parties
- Require plan participant assistance in segregating recovered funds prior to disbursement

C. Coordination of Benefits

Coordination of Benefits involves determining which of two health plans that both cover an individual, should cover the individual first. Coordination of benefits language has generally remained the same using several allocation methods. However, many plan sponsors are unaware that there is no national standard for coordination language and sponsors are given latitude to draft favorable coordination provisions with the knowledge that another plan may be required to cover the individual's claims.

Coordination of Benefits principles are only relevant when there are at least two plans which may be required to cover the same claim. One of the most popular reasons for dual coverage, is an employee who is covered under his or her employer's plan and also under his or her spouse's plan. A plan must use careful drafting to put itself in the most favorable position and avoid another plan's well-drafted coordination provisions. Every Plan should contain the following drafting provisions:

- Limit any payments for failure of participant to meet the technical requirements (such as pre-authorization) of another plan; and
- Limit the amount of expenditures when coordination of benefits provision is exercised (such as $1,000).

Adding these provisions to a carefully drafted plan document will allow health plans to recover dollars otherwise owed to the plan by participants. Plans should not assume that recovery is made for amounts paid to participants and then recovered by such participants from third parties. In addition, with the growing use of double coverage, plans should make effort to avoid subsidizing health insurance for an individual who has coverage from two separate employers. Poorly drafted subrogation and coordination of benefits clauses contribute to the increasing health care costs; correcting these provisions provide an opportunity for your company or your clients to save dollars.