

TURNING
OFF THE
SPIGOT:

FUTURE CREDITS IN HEALTH INSURANCE SUBROGATION

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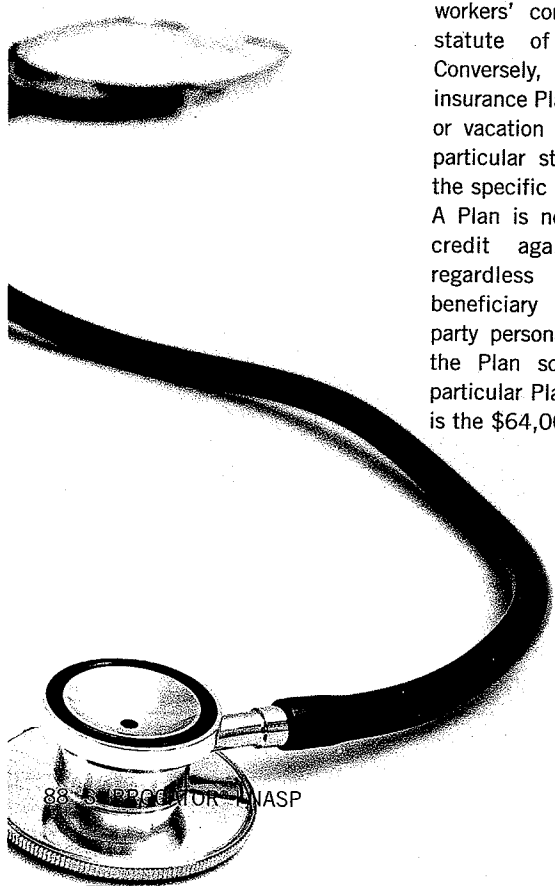
In workers' compensation subrogation settings, once a worker receives a recovery from a third-party tortfeasor and the carrier has been reimbursed for the past benefits it has paid, the balance going to the pocket of the worker is usually calculated and applied as a credit against future benefits. Unless and until that credit is used up, the workers' compensation carrier doesn't have to make any future benefit payments. Far too many within the health insurance industry fail to realize or, fail to act on, the fact that they may have a similar right to a credit which can save them millions of dollars in claim benefits when a Plan beneficiary makes a large third-party recovery.

The workers' compensation future credit is usually dictated by the workers' compensation subrogation statute of a particular state. Conversely, the right of a health insurance Plan to take a future credit or vacation is not set forth in any particular statute but derives from the specific terms of the Plan itself. A Plan is not entitled to receive a credit against future benefits regardless of how much the beneficiary recovers in the third-party personal injury action, unless the Plan so provides. Whether a particular Plan provides such a right is the \$64,000 question.

Many health insurers do not actively pursue any rights to a future credit which they might have a legal right to claim. The reasons vary - some do not act because they never realized they had the right to do so. Others have policies against doing so for any number of reasons. In November of 2007, the *Wall Street Journal* reported that while the cost of covering workers continues to escalate, employers and health Plans are getting more aggressive in their subrogation efforts. Not long thereafter, however, the *Journal* also highlighted the infamous *Debbie Shanks v. Wal-Mart* case, in which Wal-Mart tried to recoup more than \$400,000 of a \$1 million third-party recovery. As a result of negative and uninformed publicity, many carriers tread lightly when it comes to subrogating health insurance Plans. Yet subrogation remains one of the chief weapons in the war against rising health care costs. Following through on a Plan's subrogation swing by pursuing its right to a future credit is a natural extension of the subrogation philosophy - and can save a Plan millions in future benefits where the Plan beneficiary has become a multi-millionaire as a result of a third-party recovery.

The law regarding future credits in health insurance settings is more elusive than the Holy Grail. >>

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However, we are not left totally in the dark. A Plan's right to suspend benefit payments when the beneficiary makes a large third-party recovery is determined solely by the language of the particular Plan and/or Summary Plan Description involved. In the Seventh Circuit, where both the beneficiary and the Plan settle separately with the tortfeasor without allocating specific portions of the settlements to future expenses and, where they had already released the tortfeasor, the Plan remains liable for future medical expenses.¹ A Federal court in Minnesota similarly held that once a Plan beneficiary settles with a third-party, any post-settlement payments made by the Plan do not provide the Plan with a right of reimbursement.² These decisions hold that a Plan is entitled to reimbursement only for those payments made prior to the time the Plan participant settles their claims with the tortfeasor. Specific language in a health Plan is required in order to create a right to a credit.³

Precisely what language is necessary to create a right to a credit varies greatly. Plans rarely contain specific and unambiguous language setting forth such a right. More frequently, it comes disguised in the form of an exclusionary provision or excess insurance clause hinging on recoveries from third parties. The Ninth Circuit dealt with a Plan containing language which excluded coverage for injuries caused by third-party tortfeasors but promised to "advance the benefits of this agreement" subject to a lien on any recovery from any third party "to the extent of the benefits advanced."⁴ The court held that the Plan was obligated to advance benefits only to the extent that it retained a lien against payments by the third party. Once a third-party settlement was reached with the tortfeasor, there were no benefits to "advance" and, consequently, the Plan's obligation to make future benefit payments ceased. The settlement with the third-party tortfeasor satisfied the Plan's lien and released the manufacturer from liability, which resulted in the Plan having no further obligation to provide future benefits.⁵ In effect, the Plan achieved the credit through an exclusionary clause in the Plan language.

Determining whether or not a health Plan is entitled to a future credit when its Plan beneficiary makes a third-party recovery may be much more complicated than simply looking for a clause which provides the Plan with such a right. Rarely does the table of plan contents have an entry which reads "Right to Future

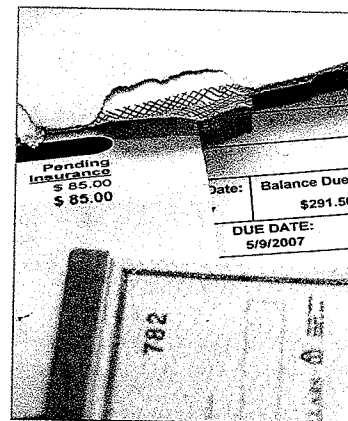
Credit Upon Third-Party Recovery." They should – but they don't. Other language within the Plan, combined with judgments, settlement agreements and releases executed in connection with a third-party recovery, can create the right to a future credit. Sometimes, all of these documents must be reviewed in conjunction with the Plan's subrogation or reimbursement provisions, in order to formulate an argument or a basis on which the Plan can take a vacation from paying future benefits under the Plan as a result of a credit. Unfortunately, documenting and laying the foundation for a future credit is often an afterthought and this is considered in the flurry of activity surrounding a large third-party settlement and a significant recovery for a health Plan based on past medical benefits it has paid.⁶ It is essential to get subrogation counsel involved immediately upon realization that a third-party lawsuit is or will be pending.

Case law with regard to a Plan's obligations to pay future benefits after a third-party settlement is sparse. A Federal district court in the 7th Circuit decided a case in which the Plan refused to make future benefit payments after the Plan beneficiary had received a large third-party recovery.⁷ The beneficiary was involved in an automobile accident for which the Plan paid \$225,132.99. The terms of the Plan required that the beneficiary provide the fund with a *Subrogation and Reimbursement Agreement*, which they did. The *Subrogation and Reimbursement Agreement* read as follows:

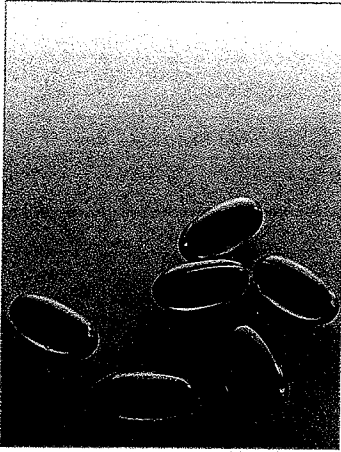
Should Participant and his/her representative receive any money or other assets from a responsible Third Party, the Participant does hereby agree to repay the TRUST FUND 100% of the benefits paid on account of the accident by the TRUST FUND, [sic] shall not however, be entitled to receive reimbursement in excess of the amount which the Participant receives from all responsible Third Parties.

The beneficiary's third-party case settled for \$1,100,000.00, and the Plan denied medical benefits submitted to the Plan for payment after the settlement based on the language of this agreement. The Federal court granted the Plan's motion to dismiss the beneficiary's subsequent lawsuit, based on the language of the subrogation agreement. The court reasoned as follows:

With respect to the more recent request for \$12,800.00 in medical expenses arising from the car accident, the analysis is very similar. >>



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These expenses, like the expenses already paid, are expenses arising from the car accident - an accident which resulted in a claim against the third party. If the Plan had paid these expenses, it would immediately have triggered Mrs. Ruhnke's obligation to reimburse the Plan for the same amount. The Plan language explicitly requires reimbursement of "a sum sufficient to fully reimburse the Fund Office for all (100%) benefits advanced" but "the Fund is not entitled to receive reimbursement in excess of the amount [the beneficiary] receive[s] from all responsible parties."

Accordingly, a reasonable explanation for the Plan's decision is that, if it paid, Mrs. Ruhnke would immediately owe the Plan \$12,800.00 and thus, the Plan owed Mrs. Ruhnke \$0 for those medical benefits. This is true, because Mrs. Ruhnke's medical expenses have yet to exceed the amount she collected from the responsible third party.⁸ The court went on to say that because there was a reasoned explanation for the Plan's decision, the Plan administrator's decision was not arbitrary or capricious and the court dismissed the beneficiary's lawsuit.

The Eighth Circuit denied a Plan the right to stop making future benefits where the Plan had effectively waived its subrogation rights in an earlier malpractice suit which produced a third-party settlement for the beneficiary.⁹ A complicating factor in this case, however, was that the Plan failed to respond to a motion in the district court to dismiss the Plan's subrogation claim.

In one Connecticut Federal District Court decision, where a health Plan denied paying future benefits after a third-party settlement, the court held that the trustee of the Plan reasonably interpreted the Plan's provisions as barring benefits for future benefits, even though the Plan had previously advanced pre-settlement benefits (subject to a reimbursement agreement).¹⁰ The reimbursement provision at issue in the Plan read, "[t]he Fund is not liable for any health expenses caused by the negligence of third parties." The court held that the trustee reasonably interpreted this clause as limiting

past and future liabilities extending to the future.

Effective future credit language can be found in roughly half of all health Plans. Even when the language is less than clear or, the Plan is less than committed to claiming such a credit due to "Debbie Shanks-type" facts surrounding the injury and the third-party recovery, a well-advocated argument by subrogation counsel indicating such intent can result in increased recoveries of past benefits. Carriers interested in more effectively claiming future credits can include clearer language in their Plans and should engage subrogation counsel immediately upon recognition that the beneficiary has hired a lawyer and plans to sue somebody - if not sooner.

ENDNOTES

1. *Davis v. Nepoch Employees Mut. Benefit Ass'n*, 51 F.3d 752 (7th Cir. 1995); *Shell v. Amalgamated Cotton Garment*, 43 F.3d 364 (8th Cir. 1994).
2. *Shell v. Amalgamated Cotton Garment*, 43 F.3d 364 (8th Cir. 1994).
3. *Salsbury v. Miller*, 582 N.W.2d 504 (Wis. App. 1998) (unreported decision).
4. *Qualls v. BlueCross of Cal., Inc.*, 22 F.3d 839 (9th Cir. 1994); see also, *McIntyre v. Carpenters Health & Security Trust of Western Wash.*, 2006 WL 118249 (W.D. Wash. 2006).
5. *Id.*
6. *Ruhnke v. Pipe Fitters' Welfare Fund*, 2005 WL 1869740 (N.D. Ill. 2005) (unreported decision).
7. *Id.*
8. *Id.*
9. *Janssen v. Minneapolis Auto Dealers' Beneficiaries' Fund*, 447 F.3d 1109 (8th Cir. 2006).
10. *Sargeant v. International Union of Operating Engineers, Local 478*, 746 F.Supp. 241 (D.C. Conn. 1990).