

Coordination Of Benefits

HANDBOOK

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Contributing Editor: Analyzing Limits On Plan Subrogation Rights

Three major rules limit group health plans' right to seek reimbursement of health benefits they paid from tort settlement proceeds. They are: (1) the **make-whole rule**, which precludes the plan's right to reimbursement if the plan participant is not "made whole" by the tort settlement; (2) the **common fund rule**, which requires the plan to bear a *pro rata* share of attorney's fees and court costs while partaking of the "common fund" created by the settlement; and (3) the **collateral source rule**, which allocates the tortfeasor's liability for damages to either the plan participant or the plan, but not to both of them. Contributing Editor Jack Helitzer reports on cases dealing with each of these rules. Ill-conceived plan documents in one case and a court that failed to observe Supreme Court precedent in another hurt plans. Only one of the three (enabling a plan to intervene and introduce health care data in a tort case) had a favorable result for the plan. **Page 2**

Medical Condition Predated Accident, So No Plan Recovery

If a person suffering from a chronic medical condition gets in an auto accident that exacerbates the condition, the evidence may not clearly indicate that the medical expenses paid for by the plan were caused by the accident. Between 1999 and 2004, a participant had back problems and had spinal fusion performed at the plan's expense. In 2004, she was involved in a car accident, which was the other driver's fault. Two years after the accident, her pain steadily increased and she had a spinal cord stimulator implanted, costing the plan \$62,000. Very soon thereafter, she sued the driver who hit her in 2004 and settlement discussions ensued. The plan and its insurer sought recovery of benefits paid for the spinal cord stimulator. The court ruled against the plan, holding that a preponderance of evidence showed no relation between the 2004 accident and the need for the implant. **Page 12**

MSP Reform Bill Would Force CMS To Provide Recovery Estimates

Legislation to make Medicare Secondary Payer reporting rules more reasonable for the business community was introduced on March 15 in the U.S. House of Representatives. The bill (H.R. 1063) would compel the Centers for Medicare and Medicaid Services to create a "pathway" that would calculate and provide MSP repayment amounts to the parties in injury lawsuits *before* they reach settlements. Proponents say H.R. 1063 would soften the impact of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, which was designed to ensure that private payers take more of the financial burden for Medicare-entitled individuals. **Page 15**

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Update Pages

- ¶624 — Updated discussion of collateral source rule
- ¶911 — Replaced charts to reflect new Montana COB regulation
- ¶914 — Updated charts section on state laws

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